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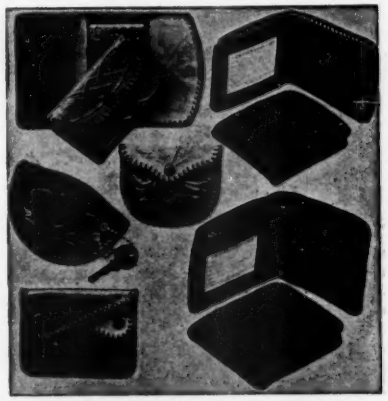

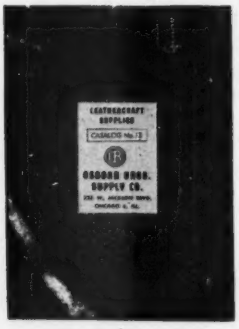

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THE REHABILITATION CENTER

SOME ASPECTS OF A PHILOSOPHY

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The comprehensive rehabilitation center is evidently assuming an increasingly significant role in society. There is a lack of such facilities but there is more concern with the problem of the severely disabled and fuller recognition of the value of the "total approach." A great deal of interest in teamwork operations has been evinced by both the professional and lay public. Definition of a basic philosophy is needed to establish present practices and to set goals for future development.

The following interpretation[1] is an effort to summarize and present a number of possibly significant aspects of a philosophy. Some of the points made are directly related to present measures in some centers; whereas others represent an attempt to define and describe what seems to be a movement or a desirable step towards certain philosophic principles.

The "comprehensive" rehabilitation center, the goal of most rehabilitation facilities, covers fully the main areas included in the definition of the National Council on Rehabilitation: the physical, mental, social, vocational and economic side of man. Such a center may become a university of treatment and education if it organizes its knowledges and beliefs intelligently. *For it may well be that the conceptual progress of the science of rehabilitation depends upon the ideas and convictions already sown and nurtured in the comprehensive center.*

The literature has given some indication of a developing philosophy principally in the writings of Smith,[2] Kessler,[3] Greve,[4] Rusk[5] and Hamilton.[6] The committee on rehabilitation centers[7] has collected a number of observations about several leading centers. As yet, however, these writings have been fragmentary in defining a philosophy due perhaps to the fact that the comprehensive center has only lately appeared on the scene and also perhaps because rehabilitation has not yet come of age.

It may be obvious to say that a center should state its philosophy and define its operational principles, but these things are often avoided. Yet how can any institution function reasonably without a clear statement of its aims and intelligent planning for their execution? It is often in the latter part of this statement that the center may fail. It is quite easy to subscribe to important statements as, for example, the definition of rehabilitation of the National Council on Rehabilitation, but many institutions professing this definition fall far short of filling its promises, yet may claim to do so. For example, one does not cover the vocational and economic side of man by the presence of a vocational counselor and still less by the presence of a psychologist with two courses in vocational guidance or by a social caseworker who once was employed in industry or an industrial psychiatrist or an occupational therapist. One must provide the *setting*, the *means* and *qualified personnel*. Vocational counseling, special vocational testing, exploration, training, workshop and special placement are all necessary within a coordinated framework to satisfy this commitment. John Dewey[8] says, "To profess to have an aim and then neglect the means of its execution is self-delusion of the most dangerous sort." A treatment unit or center may be guided by an ideal, but ought to recognize its own limitations.

One might say that a comprehensive rehabilita-

tion center makes a number of basic assumptions:

Rehabilitation is a social problem — one that has its roots set firmly in the life of the community. It is the community that spawns, nurtures and produces the human being that is its raw material. It is to the community that the person returns a success or failure by community standards. It is the goal of the center to so treat, educate and prepare its clients that they gain maximum community acceptance in the light of the center's facilities, available resources and surely limited knowledges.

The center places itself in a position of final community responsibility; the last place for the resolvement of a variety of community inadequacies: lack of facilities, isolated and unconcentrated efforts, ignorance and unconcern. As an important instrument of both the lay and professional community, it must be responsible to such groups in justifying its efforts, in maintaining high standards and in maximum cooperation for the mutual enhancement of all connected parties.

It exists primarily for the client and is centered about his needs. The center's values are derived from their relation to the client's benefit. Its development stems from his treatment as professional sciences advance and as facilities increase.

It holds firmly to the belief that all treatment is total since the whole man must be treated, i. e., no treatment is solely medical, social, psychological, vocational or economic; but all these aspects assume a major or minor role depending upon the circumstances and the nature of the client's needs.

An outgrowth of these assumptions results in a number of operating principles or characteristics of a comprehensive center. They may be summarized under eleven headings: complete, definitive, dynamic, practical, cooperative, educative, augmentative, organismic, investigative, professional and democratic. A brief delineation of each aspect will serve to illustrate the principles involved.

Complete. This is a phenomenon brought about through necessity. It is the answer to the need for dealing with the whole person. Those who were severely disabled presented such interrelated problems that it became obvious that only by providing services which treated all their needs could a favorable result be expected. Perhaps in no other endeavor in any professional field does one find such a variety of professions in the medical, social, psychological, vocational and economic areas.

Definitive. Because of its vari-professional services, the opportunity to see many sides of the client as well as the overall picture is available. If any non-vocational professional were to say, "This person will never work," he may be incorrect unless he is well aware of the types, grades, variety and levels and requirements of jobs in the working world. Certainly also, for example, a non-medical professional may say the same and be incorrect since he might be unaware of what could be done medically. This is true of each and every service. The dynamic nature of a continual exchange of information on all sides is reflected in a more accurate and definitive opinion.

Dynamic. This characteristic follows naturally from broad and definitive services. When a client is under observation, the originally static opinions become dynamic for, as information grows on the part of every service, diagnoses are revised and altered. This modulation continues until the disabled person is no longer a client and even then sometimes goes on in follow-up investigations.

There is a concomitant to dynamic operation: it is flexibility. The center should neither bolt down its furniture nor its ideas, but must be prepared to keep changing as sciences and rehabilitation concepts change for, as Smith says:

The Institute was founded on the theory that rehabilitation is dynamic — that it must keep pace with the progressive transformation of society; with the scientific advances in the various specialties in medicine, including psychiatry, in psychology, social work, education, and industry; and above all, with the changing needs of the disabled as a group . . .[9]

Davis, Greve and Hinshaw all stress this latter point. However, it is more than flexibility; it is open-mindedness as well. One frequently finds both in industry and in social agencies how often the accumulations of outmoded procedures, stereotyped ideas and stagnated personnel which an establishment may gather over the years results in an unprogressive performance. Democratic administration, upgrading and retaining a good staff, and exchange of personnel with other centers and agencies along with affiliations with outside universities, hospitals and business firms all should help to keep the center alive.

Finally a realization of the limitations of all sciences and present rehabilitation practice should avoid the self-satisfied view that prevents progress.

Practical. Combining all services under one roof is not only good treatment but convenient and efficient for the client. Betsey Barton speaks of avoiding, ". . . the long, heart-breaking trek from one man to another in search of help which must always be partial until it is gathered in a correlated program under one roof."[10]

Time, effort, travel and consequently also costs are saved in such a medium. From the community point of view, overlapping and repeated services and multiple administration overhead are avoided.

Another advantage the center has is the opportunity to employ its professional people at *their highest functional capacity for maximum efficiency,* i.e., in much professional work outside we find each one performing in a broad fashion and often not too effectively in the overlapping areas of other fields. In the comprehensive center, someone else can do the job better the moment one leaves one's strict professional boundary.

Finally to emphasize practicality, the center should orient its services realistically through the

funnel of its vocational areas. Clearly the Federal-State system has taken that type of orientation. Its efforts cannot be dispersed toward a vague "ideal" community citizen which seems not only undefinable but impractical in terms of staff, facilities and the inexorability of time. There are thousands of people outside the doors of a center who are maladjusted, untrained and in poor health, but who do not happen to be classified "disabled." Our obligations must be tempered by the magnitude of the problem and available means. What should not be overlooked is the center's main purpose of providing services to remove various bars and stumbling blocks to a job as a minimum, and secondarily to the broader aspects of a more constructive contributing life.

Cooperative. The comprehensive center cannot afford to stand alone in spite of its wealth of services. Perhaps this might be said of every treatment center today. It cannot keep all professional specialties under one roof, but must call upon the community for services beyond those which the center can supply. The large number of staff members and the variety of disciplines as well as the cost of so many specialists make it mandatory that the center affiliate itself with a local university, hospital, clinic, school and other community facilities. Consultation may be exchanged to the benefit of each party. At the university, as well as in the community, specialists not ordinarily available would be obtained and in turn internships in all professions sponsored. It is probably best to relate to more than one agency of its kind whether a university or hospital in order to avoid local restrictions and retain freedom of scope and action.

Greve would add, ". . . consultant service to factories regarding job placement."[11] The center in addition may leave its immediate area and send out, ". . . mobile clinics in rural sections,"[12] according to Kessler. Greve agrees and says the center should sponsor, ". . . a traveling team of specialists (medical, case work, physical and vocational rehabilitation) for visits, on invitation to counties having no special service."[13]

An important step towards establishing the center as the focus of community teamwork would be to make it responsible to the community for its actions and procedures and so it ought to be free and open for inspection to any person or organization qualified to pass judgment.

Educative. The center performs vital educational services for the community as well as within its confines. This aspect is secondary only to its treatment function. The center is an applied medium superior to the theory of the classroom as it is more real, integrative and stimulating as well as offering greater professional insight. It should offer training for advanced students in all its various disciplines. Furthermore it should provide in-service training for its staff both on a formal and informal basis. Symposia, fora and discussion groups may be a continual source of education. Formal staff meetings cannot perform these functions. Rehabilitation, with its philosophy and practices still unorganized, needs ideas, theories, new concepts. When so many professions work together, many interprofessional problems arise and may not be adequately discussed and defined. Ordinarily each profession works within its own isolated intellectual sphere, but in the comprehensive center there is a wonderful opportunity for testing one's own field and the validity of many of its assumptions through contact with other professions who are also treating the same client from the viewpoint of their discipline. Such meetings and discussion of common clients and interrelated problems should lead to cross-professional education and fertilization: an understanding of the values and limitations of other professions, a release of feelings, thoughts and questions about each other's methods and a stimulation to all in the formulation of new ideas.

Public relations is a definite area of concern. However this should not be just publicity, but public education as well. This being the case, a professional group should pass upon all releases to avoid violation of professional ethics and the alienation of the staff. While in some instances exploitation of the client through continued public exhibitions has been done, this would never take place if the professional staff were consulted. Publicity of this nature tends to destroy rather than increase public education.

Information and knowledges of many kinds require a special library as a resource for the benefit of the staff and the community.

One more facet of education is that of promulgating the center's beliefs on prevention. Lord Beveridge said that, ". . . prevention is, of course, as important as cure or alleviation."[14] This does not mean that the center should speak of the avoidance of disease or accident since other agencies are more qualified to do this, but rather prevention of the exacerbation of the physical, mental, social, vocational and economic sides of disability. The center, armed with a knowledge of alleviation and augmented by a study of the immediate client situation, may trace the growth of the handicap to its crucial moments in time. This knowledge should be passed on to the special educator, the physician, other treatment professions, compensation authorities and industry. The reconstruction of the causes from confusing and complicated clues is indeed a "detective" story rehabilitation style.

Augmentative. A distinctive characteristic of a rehabilitation center is the "augmentative" approach as contrasted to the "job feasibility" approach of the Federal-State program. In the latter case, restrictions based upon the law are reflected in criteria centered about job possibilities while the center, on the other hand, has greater scope and freedom for its treatment.

The augmentative approach envisions a continuum—a line from complete dependence on the left to the complete independence of a self-sustaining, family-providing, community-contributing individual on the right side. This line may be called constructive living starting with complete bed dependence, self-care activities, constructive use of time and contribution of benefit to the home and extending to volunteer contribution to the community, homework, sheltered work, part-time employment, full-time employment and to the optimum community citizen as the peak goal. The "job feasibility" approach begins often with homework and extends forward to full-time employment while the "augmentative" approach extends in a broader spectrum from, and including, self-care to above full-time employment approaching the community citizen ideal.

This latter approach guides the client into modes of living commensurate with his total life situation. Consequently everyone should be taught something along the line of his increasing fulfillment: if not a trade, then a skill or an avocation; if not an avocation, constructive use of time. If the disabled client cannot be taught to walk unaided, then he may be instructed as to how he can walk with canes, with crutches, get about with a wheel-chair, or merely take care of his physical needs. If he cannot achieve a reasonable level of education along with an adequate knowledge of his disability, then he should be taught at least a minimum of skills in reading and writing with an awareness of what is detrimental to himself. If he will not be a socially adequate person, then he may become one who is at least interested in the company of others as a medium of fulfillment. If the client cannot be completely rehabilitated, at least then a level reasonably available to him would be the aim. It is consequently an *augmenting of the client's abilities towards a more complete and constructive life.*

While the "risk" in this group is much greater, there is nothing to lose but the hope of a job and no one can ever state flatly that many in this area, even when given up by the center, may not become employed later in life when circumstances change whether it be the client, the environment or further scientific knowledge.

The augmentative approach on the part of a center predicates several assumptions:

a. It is not in competition with agencies boasting of high percentage of successes. Clearly "success" depends upon the relative nature of the result and client admitted.
b. It is the right of an individual in a democracy to have an opportunity to develop his capacities no matter how small the eventual contribution to society. Some clients have never had a chance or an adequate chance. Certain of the congenital or early injured have not had sufficient opportunity to grow in total practical experience.
c. Reliance is placed upon the changes which a concerted vari-professional attack can bring about. There is still no means of prognosticating how far an individual disabled client may go. Actually the chief bar may be lack of sufficient professional knowledge. Consequently previous diagnosis of great severity is not necessarily reason for rejection until the center has made its own diagnosis.
d. It accepts the fact that poor rehabilitation candidates are its business. This is not easy to recognize since in most other human endeavors logic demands a selectivity process.

The method of this approach is a "living period"[15] evaluation—an opportunity to grow in a purposeful environment, an observational period to clarify, revise and re-estimate the opinions of all—a dynamic method of assessment instead of a one-shot static method. The early-injured client often must have a program of "habilitation" which must start with an appreciation of the fundamentals of work habits and adult responsibility before or during the usual rehabilitation approach. With all clients, it is the optimistic application of services conjunctively and interrelatedly.

Organismic. A realization of the complicated nature of rehabilitation is an important consideration. It is not only that there are physical, mental, social, vocational and economic aspects pure and simple, but medico-vocational, socio-psychological, and medico-psychological problems as well. Yet this obviously does not properly categorize all the problems nor does it consider more complicated medico-psycho-vocational problems and, in truth, the fact that no treatment is medical, social or psychological, but that all treatment has its total aspects. To put it another way, all treatment should be organismic treatment. Acceptance of this principle necessitates an effort to achieve this higher professional level through interdisciplinary integration within the center and interagency cooperation with the surrounding community. This viewpoint is perhaps the acme of the individualized client approach.

The principle of an organismic teamwork of professions has become a necessary construct to compensate for two situations: first, the severity of the client's problems; and second, the degree of specialization not only of professions but within professions.

The reasoning behind this latter point is as follows:

Mankind has attempted to solve its problems through the

constant extension of various bodies of knowledge. These frames of references have fallen into groups with rather arbitrary boundaries called sciences or professions. Moreover the acquisition of more and more information within each sphere has forced each profession to sub-divide itself further and further. Yet as each new group becomes more specialized, it loses some of its ability to relate to the wholeness of knowledge. A sense of relative value and proportion becomes more difficult to reach. In the treatment of a human being, each profession takes a particular view of man for its emphasis. However, these professions have examined man with a false assumption: that an individual could be studied in fragment and then the observations be related with full meaning to the wholeness of his nature. Yet each discipline has become so broad and consists of so many specialties within the profession itself that it has become difficult to relate the information even in its own framework and certainly far away from the total man himself.[16]

Interagency cooperation has yet to attain the level it should for numerous reasons. Some of the difficulties are: the lack of adequate agreement in some areas of prerogative; a curious disinterest in a client who has left the confines of the institution; estimation of each other by the point of contact rather than by the quality of services; insufficient acquaintanceship with the services of local agencies; jealousy and rivalry engendered in a large measure by non-professional vested interests competing for the public dollar, prestige and their own expansion and in addition the narrow-minded professional who plays a non-cooperative role howbeit more subtly. Occasionally one finds insecure people who resent the implication that another agency might help the client when they could not. Frequently an agency assumes that now for the first time the client will be handled correctly regardless of another's experience with the client. Lack of understanding and poor communication are inveterate enemies of mutual trust. It is vital for a community to preserve an adequate standard of practice since the carelessly administered and poorly staffed agency has a tendency to destroy interagency cooperation within the whole community.

Investigative. The investigative aspects of a center's philosophy begin before the disabled person becomes a client and continue long after he departs. Both Hamilton[17] and Kessler[18] stress the importance of case finding as necessary for a proper continuity of community services. In this area the center should have a formulated program with other community agencies to direct, in a two-way fashion in some cases, the disabled person in a continuous series of meaningful sequential treatments until independence is reached.

It is incomprehensible that follow-up seems to be considered as an after-thought by so many agencies. Just what is the reason is difficult to say. Often lack of funds will be given as the cause. There is also evidently something to the fact that an agency might be afraid of some unpleasant implications. For the logical necessity is clear if one is interested in assessing and improving the quality of its service. Not only does a follow-up frequently prove of aid to the client but it enables the agency to orient its treatment and change its practice if necessary since the true test is the ability of the client to meet and sustain himself in the medium for which he was prepared. This objectivity is certainly of greater importance than the judgment of how "successful" the client was deemed upon closure. Such check could also lead to the maturity of reporting upon failures as well as successes.

The center is one of the most ideal places for research since the highly specialized nature of its work, the serious and complicated situation of its clients and the conjunction of so many disciplines all provide a fertile field. Indeed, *a center is so vital a repository of knowledge that it cannot fully justify its economic cost unless it produces contributions to better practice in rehabilitation and its constituent sciences.*

It is generally agreed that the center accepts more seriously disabled clients representing statistically less chance for placement. It spends a great deal of time, money and effort and uses its personnel freely. Some might quarrel with the logic of this procedure and state truthfully that a "job feasibility" screening would result in a greater percentage of placed clients. Yet the "augmentative" approach, as stated previously, considers each individual entitled to maximum services by means of a thorough trial for whatever benefits may accrue to him. Furthermore it is something more than a humane and democratic principle. For there are additional gains under this philosophy in serving the interests of science. Much of present-day fundamentals in rehabilitation has come from the rehabilitation centers. Certainly their staffs have the opportunity of obtaining an unparalleled knowledge gained through handling difficult cases. Consequently this information should be analyzed, refined and passed on for delivery to the field. Additionally, the opportunity for combined research by several professions should not be lost.

There is one further vital need: that of making complete case histories rather than collections of reports. If everything about certain cases were reported on an almost daily basis, with frequent summary and re-estimation and with a complete final assessment; it would be valuable for the immediate future, of profit by comparison in the next ten years, of interest beyond that, of curiosity next and still later of historical value. Yet today we must be establishing the basis for such subsequent comparison. If in the past better case records were kept we would probably be further along today. The heritage of such rich material should not be lost. Modern visual and sound recording devices

to aid the process of reporting are certainly distinct advantages to present-day methods.

Professional. Rehabilitation with its growing complexity is increasingly aware of the importance of professional operation. In the past the field was all too willing to accept anything and anyone of fancied contribution to its effort with little question. Today it must evaluate its present situation and any new avenue or problem through the eyes of professional estimation. A definition of competent professionalism is not as simple as it seems and perhaps cannot be defined other than by the agency itself. However, the comprehensive center requires high qualifications in its positions. Furthermore any new staff member ought to be screened by the staff who are members of the team because of the exceptional pertinence of the relationship.

Democratic. An agency, whose goals are services to a human being, cannot forget its dedication but must direct its efforts clearly towards such ends. The nature of its purposes requires that those who are trained and experienced in the provision of such services be full partners in the control of the agency's operations since definition of ways and means of delivering these services lies within their knowledge and professional responsibility. The center cannot afford to follow the authoritarian concept of administration such as is too prevalent today. While even in the making of a manufactured product, a democratic approach is of increased concern, professional ethics demands that decisions which will eventually affect patients or clients should not be made without full hearing. Frequently professional unconcern with the important responsibility of policy making binds both the professional and his client to intolerable situations at a later date. It is at this point the professional decides to leave the position and may unfortunately again become passive in this matter in the new situation. Professional organizations with some exceptions have tacitly encouraged this by their docility.

A democratic philosophy is accepted by all but it is the practice which proves whether the understanding of such is genuine or not. It is clearly evident that an agency in the nature of the rehabilitation center must be democratically controlled to permit full professional freedom within the scope of professional ethics. As in a true democracy, internal controls are qualified by external controls, i.e., by local, state and federal modifications. In a private center, these latter controls carry much less weight. It is therefore necessary for the governing board to be fully representative not only of the community but of the professional areas as well. Democracy is not a clumsy but happy way of doing things, but is a far more practical means in the light of psychological findings since cooperation by consent and mutual trust is the most effective cooperation.

Progress in science has been characterized by the boldness of the innovator armed with a principle. One cannot expect to establish better practice without criticism. The individual or organization easily dissuaded by the inevitable comment of the status-quo group is without a firm philosophy.

The comprehensive rehabilitation center provides opportunity for defining and exploring the individual sciences as well as rehabilitation practice. For total observation it is a human laboratory without a parallel. A philosophy which will encompass its broad services, permit their development and lead them to better methods is most desirable. The sooner this is approached the quicker all of rehabilitation practice will progress.

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(*Continued on page* 270)

THE TEACHING OF WRITING TO CEREBRAL PALSIED PATIENTS

Foreword: To exchange ideas and discuss their therapy problems in relation to the cerebral palsied, the occupational therapists in and around New York City have been meeting bi-monthly. This paper is the result of their combined thinking about the problems of teaching writing. A previous article carried in the July-August, 1953, issue of AJOT pertained to their discussions of feeding training. The occupational therapists contributing to the following article represented the following clinics:

Bergen County Cerebral Palsy Center, Ridgewood, New Jersey
Branch Brook Public School, Newark, New Jersey
Columbia University School of Occupational Therapy, New York, New York
Coordinating Council for Cerebral Palsy, New York, New York.
Godmother's League, New York, New York
House of St. Giles the Cripple, Garden City, New York
Hospital for Special Surgery, New York, New York
Lenox Hill Hospital, New York, New York
New York State Rehabilitation Hospital, West Haverstraw, New York
Passaic County Cerebral Palsy Center, Clifton, New Jersey
Public School No. 85, Bronx, New York
Public School No. 135, Manhattan, New York, New York
Public School No. 118, Queens, New York
Vanderbilt Cerebral Palsy Clinic, Columbia-Presbyterian Medical Center, New York, New York
Westchester Cerebral Palsy Association, Bedford Hills, New York

AIMS AND OBJECTIVES

The purpose and scope of this paper is to outline briefly the indications for and methods of teaching writing to the cerebral palsied child.

The most obvious need for learning to write concerns the child who will be physically and mentally capable of attending school. The ability to write with relative facility is an important element in academic achievement as well as a necessary aspect of independence in every day living. Many cerebral palsied persons who have had difficulty from a motor standpoint in learning to write have relied on the typewriter as their sole means of written expression. However, the use of a typewriter is, in many instances, impractical. First, it is impractical because of the problem of portability. Second, in a situation where a typewriter would be unavailable, the disabled individual should be able to write at least a minimum amount: e.g., his name, address and other personal information. These situations arise in applying for a job, signing legal documents, etc. Third, in a classroom environment, the child who is mildly to moderately involved should be taught to use a pencil for his classwork and tests that require words and numbers, leaving the typewriter for long written assignments at home.

If the written word is to be used as a means of communication for the child who has unintelligible speech, writing would be a more practical method of expressing himself than typing, provided the child is capable of making legible symbols with a pencil or writing tool.

DETERMINING READINESS

Before the therapist commences on a program of writing with the cerebral palsied child, she must first determine whether or not this particular child is ready for this activity. In order to write one must have certain basic physical, intellectual and perceptual abilities upon which all writing depends. The therapist should evaluate the child as best she can, making sure she evaluates the child's perceptual ability according to the average standard for his chronological age group. Some of the guides for perceptual readiness that can be used by the therapist, are the following:

1. Can the child *match* concrete, familiar objects and pictures? Pictures of abstract symbols and forms?—e.g., pictures of circle, square, triangle.
2. Can the child *discriminate* between concrete forms? Abstract pictures? (In a set of various picture shapes ask the child to point to the square, circle, etc.)
3. Can the child *reproduce* from a sample, simple, familiar shapes or pictures using clay, paints, peg boards, etc.?
4. Does the child seem to understand the principle underlying a system of symbols?—e.g., does the child recognize the written symbol "3" as indicating three of any given objects?
5. Will the child be able to spell out at least the minimum vocabulary necessary for getting him about in his environment?

An analysis of the physical abilities necessary for the individual to accomplish writing is also essential. The following have proven to be helpful aids to the therapist in formulating the decision to teach the child to write:

1. Can the child sit with good posture in an upright chair with feet on the floor? This may be aided with braces and a simple restraint.
2. Do the child's arms rest comfortably and quietly on the table? The table height should be adjusted so that the child's elbows are flexed to almost 90 degrees and the shoulders are slightly abducted.
3. Does the child have good to fair head control? Good eye to hand coordination? Adequate vision?
4. Has the child's handedness been determined?
5. Does the child have moderate to good control of any one of the following parts of the body: trunk, shoulder, wrist? Any one of these may be used to control the direction of the writing implement.
6. Can the child's hand maintain contact with the paper for about fifteen seconds using finger-paints?

7. Can the child hold a thick crayon or kindergarten pencil? If not, can splints and/or other aids be devised to facilitate manipulating or grasping the pencil?

A normal grasp should be strived for, but if necessary, any type of grasp or hold on the writing tool should be accepted if it results in increased legibility and ease of performance.

If the cerebral palsied child fails to have these minimum perceptual and physical skills after a reasonable period of practice, a typewriter should be considered as an alternative.

THE TYPE OF WRITING TO BE TAUGHT

There are two schools of thought as to the kind of writing the cerebral palsied child should learn. One of these is the cursive or script method. The principle of this method is based on control through relaxation and rhythm. The continuous flow or link from one letter to the next is believed to aid this rhythm and make for better

Fingerpainting is an excellent pre-writing activity for gross function in learning to produce motions inherent in writing.

control and coordination. Brain injured children frequently have difficulty in spacing letters due to perceptual losses. Cursive writing, therefore, is thought to lend itself more effectively to developing kinesthetic perception of word forms.[1]

The other method is manuscript or printing as done in the first grades in elementary school. According to this school of thought, printed letters require less fine coordination and fewer motions in forming each letter, and are, therefore, better suited for the more handicapped child. Printing is more legible since each letter stands alone; the connective link in cursive writing frequently is the cause of the illegibility. The printed letter is more easily controlled by the child, because these letters can be made in many ways aside from the orthodox method of production. Cursive writing, on the other hand, limits the child to only one method of producing the letter. This is an important point when considering the handicapped person. Printing, therefore, seems better suited to meet the individual needs and differences of each child. In addition, the child who is ready for writing has been exposed to his basic instruction in reading. Since the child has become familiar with typography in his initial reading, it seems logical and natural to carry over printing into his writing.

In making the decision as to which method of writing the child is to be taught, the therapist should consult the teacher and cooperate with her. When the child is attending school, it is usually advisable to use the method of writing established by the educational system. The child may become confused or disturbed if his therapist uses a different method of writing from the one which he is exposed to in school. It is the occupational therapist's responsibility to assist in the mechanics of teaching writing from the physical angle.

The techniques of teaching writing in this article refer primarily to the printing method. For those who are interested in the cursive techniques, they should refer to Margaret S. Rood's thesis, *Writing Training as a Treatment Procedure for the Cerebral Palsied.*[2]

THE METHOD

The next problem for the therapist is the actual training of the child. There are a number of techniques, methods and aids which the therapist should utilize according to the needs of the individual.

It is strongly recommended that the very young and even the school aged child who has not had any writing experience, should go through a period of pre-writing activities. The purpose of the pre-writing stage is to help the child become consciously aware of the specific motions inherent in writing (curves, verticals, horizontals, and diagonals) and to reproduce them. The child must also learn to stay within a prescribed area of space, gradually decreasing the outline form, and learn to reproduce concrete and abstract shapes appropriate to the child's developmental level. Frequently the brain injured child requires having these concepts reinforced through the use of the child's visual and kinesthetic senses. The following list of materials can be utilized for these pre-writing activities at the same time helping to develop the visual-kinesthetic concept of these very same motions which are incorporated in actual printing:

Finger painting
Poster paints, brush work
Crayoning
Stenciling of lines, shapes, and later, letters
Marking lines, then letters in clay as the child becomes more experienced
Cutting out paper shapes and then letters, fingering these cut-outs

Making "dot pictures" using simple, basic shapes, lines and curves
Playing the game of "dots"
Drawing on blackboard as exercise for shoulder control only
Visual pictures of words for the child who is ready for spelling

As the child approaches writing readiness, an evaluation should be made of his specific limitations in forming the actual letters of the alphabet. The therapist should: (1) Have the child attempt to copy simple words containing varied letters of the alphabet in capitals; (2) Observe which lines or curves he has the most difficulty with; (3) Concentrate on these lines as exercises alone or as part of his pre-writing program or, if possible, incorporate them into actual letter production practice.

As the child proceeds to the phase of actually writing letters and words, these additional materials and equipment should be used:

(1) *Paper*: Newsprint or the backs of old wall paper books. The paper should be ruled or boxed off. (Use circles if cursive writing is being taught.) Stabilize paper to the table by means of masking tape, scotch tape, clamp boards or magnetic boards.

(2) *Pencils*:
- (a) Kindergarten pencils with soft lead.
- (b) Pencil pushed through sponge ball for easier grasp.
- (c) Other adaptations may be developed and used as necessary.

Other aids include:
- (1) Inclined writing boards.
- (2) Small wooden platform attached to underside of forearm with gliders on bottom to facilitate movement of arm across page.
- (3) Talcum power dusted on forearm to reduce friction on the working surface.

PROCEDURE

The first step in the procedure is the copying of letters. This may be accomplished in three ways. The therapist may have to employ each of the following three methods of copying in succession or, depending on the ability of the child, may eliminate one or two of these processes:

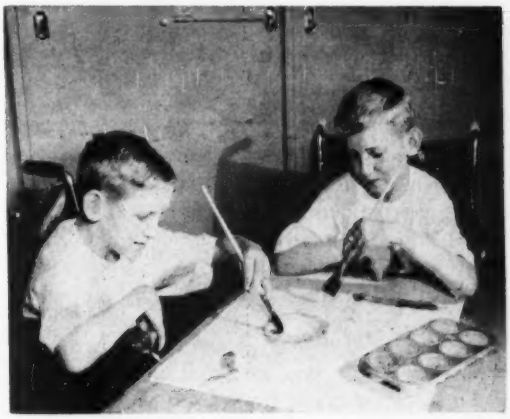
(1) Tracing on onion skin or tracing paper from the letter beneath.

(2) Tracing directly upon the therapist's example on the same sheet of paper.

(3) Copying from an example on a separate sheet of paper. A variation is to use modeling clay lining the bottom of a shallow pan and have the child formulate the letter with a stylus. It is theorized that the resistance offered by the clay reinforces the child's kinesthetic sense of the letters.

If the child finds the transition from tracing the example to free copying too difficult, the therapist may introduce an intermediate stage of guide dots to indicate the beginning and end of a stroke.

It may often be helpful if the therapist pronounces the phonetic sound of the letters as the child is writing them in order to develop his kinetic-auditory association.



Learning to make purposeful strokes with a large brush and poster paint is another interesting pre-writing experience.

The above steps should be graded within height and width boundaries. A suggested size to start with is a block two inches by two inches in which the letter is to be made. The size of the boxes should be gradually reduced as skill increases. As the child progresses in his ability to produce consecutive letters, the vertical space lines should be eliminated.

The child should begin his printing activities with capital letters, because they consist predominantly of straight line strokes which are easier to produce than curves. The alphabet consists of eleven capital letters with curves, as compared to nineteen small letters. Eventually the child can be introduced to small letters as he improves. It is usually advisable to start the child off with learning to print his own name. His name, of course, is the most familiar noun in his vocabulary and it may serve as a valuable incentive for him to be able to write it himself.

The techniques described have been utilized by the authors and, in their experience, have been found to be relatively successful. It should be understood that the undertaking of teaching the cerebral palsied child to write is usually a long-range project which may cover a period of a few years. If the inexperienced therapist has given careful consideration to the prerequisites neces-

(*Continued on page 270*)

INDUSTRIAL THERAPY

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[*Editorial note*: The occupational therapy department at Warren State Hospital is responsible for an industrial program, but only for female patients; it co-operates closely with the program here described however. While this arrangement has obvious disadvantages — as does the absence of any basic occupational therapy for male patients — the results obtained by the industrial program make it worth the thoughtful attention of those interested in increasing the therapeutic value of such programs.]

It is gratifying to note the upsurge of interest in industrial therapy as an extension of occupational therapy in various mental hospitals as evidenced by the many articles written on this subject. In this article we wish to discuss the methods of conducting industrial therapy in the care of male patients in this hospital. Every hospital is concerned not only with the care of acutely ill patients but with the large accumulated group of chronic patients. As a specific illustration of this statement we may cite the Warren State Hospital resident population. Of the 1462 male patients in the hospital at this writing, only 320 had been in the hospital for less than three years. The 1142 other patients represent the typical daily population of the average state hospital. Successful modern therapies are sending home a majority of the steady stream of new patients. Excluding the patients over 60, only two out of ten new patients, in this hospital's experience, prove to become long-time, chronic hospital residents. Yet it is those two out of ten today, yesterday and tomorrow who make up the bulk of a resident population which must be dealt with.

It is unfortunately true that spontaneous recovery after many years of hospitalization is infrequent. Unless there is extensive rehabilatory treatment these chronically ill residents have little hope for a return to the community. The adjustment of such patients to hospital life therefore is vitally important. The hospital provides the patient with his sole environment. Even though he may live in psychotic seclusiveness he cannot escape the communal life. Good hospital management of the social structure among patients contributes to their individual welfare. The mentally ill patient can become an extremely difficult nursing problem. The very fact that he is too psychotic to leave the hospital means that he is potentially or actually poorly adjusted, from the view point of others who must live with him. This difficulty in living with others may be magnified as the years pass and the patient often becomes more restless with the awareness of continued confinement against his will. Left alone such a patient can be expected to revolt. Some vegetate endlessly in apathetic idleness. In others idleness in confinement creates restless frustration to which they must give angry expression. This results in the noisy, quarrelsome, destructive behavior that requires restraint and isolation in too many hospitals.

The obvious alternative is to divert this energy from psychotic, disintegrated behavior into useful and organizd outlets. It is our experience that industrial therapy helps to increase the social structure among mentally ill patients. A large scale program of this type of therapy has been conducted at this hospital for 30 years.

Prior to the onset of an organized program, 70 out of 800 male patients were employed in hospital work. These were patients selected because of good hospital adjustment. The primary motive was to secure someone who could perform a needed job.

EXTENT OF PROJECT

In 1920, Warren State Hospital started an industrial therapy program with the object of placing patients in a work environment, as therapy, regardless of how much they could produce. The patient's mental and physical health was of first importance and the type of work done simply a medium through which such aims could be attained. First, one pilot group was recruited from among the acutely ill and the better adjusted chronic patients. The men were given the job of maintaining the grounds, each one encouraged to contribute what he was able. At first some men would do nothing but stand about but eventually nearly all could be encouraged to do some physical work. As patients took an increasing interest in their work they also became more aware of each other.

By degrees more and more patients were added to this group until some 50 patients and five attendants were active. After three or four months it was decided to expand operations. After carefully selecting nuclei from among the patients, five separate groups of about 15 patients each were activated. Each group, under the guidance of two attendants, had the potential of expanding to 20 or 30 patients. As time went on this procedure was developed until, at present, almost all of the patients physically able are engaged in some type

of occupational activity away from the wards.

As the years went by and the patient population grew, another problem presented itself: that of too many workers and not enough work to be done. This was solved to a great degree by the simple expedient of ignoring new and improved labor-saving devices. As an example, this hospital has almost 40 acres of lawns and shrubbery, but no power mowers or electric clippers. The lawns were sectioned off and a competitive spirit was developed as groups vied with each other to see which had the best looking and neatest cut lawns. This project alone permits the use of four separate groups comprising 94 patients in the summertime. During the winter these same groups are kept busy with the winter care of the streets and sidewalks. In such groups it is possible to integrate the simple schizophrenic, the chronic bench-sitter, and the individual in need of "push therapy."

Another example of creating a work outlet was started with the introduction of a sand and gravel-washing rack.. A portion of the hospital hill was dug into and a hand-operated wash rack was built. All work is done by hand with shovels, screen, picks and wheelbarrows. In addition to the advantage of free sand and gravel for hospital use, men can be kept busy all year around.

Lately a complete canning department was inaugurated to supplement the hospital's food supply. Here too hand work is stressed. There are no peeling or other labor-saving machines, the food being processed almost entirely by hand. (For this seasonal work many women patients are recruited for their first job or from their usual industrial pursuits.)

Job training is not primarily the problem in rehabilitating the mentally ill. Part of the function of a mental hospital lies in its ability to create in the acutely ill patient the will, as well as the capacity, to assume responsibility, to revive his self-interest, to restore his hope for the future, often to teach an attitude of cooperation and, through the medium of work, to build self-confidence in the patient's ability to take his place in the economic worth of the hospital. The program must be simplified to its essentials because of the ever present shortage of personnel.

Superintendents may be concerned with the cost of extensive outdoor therapy. Clothing, tools, extra attendants loom up as obstacles where a hospital budget must of necessity be limited. Here it should be pointed out that the clothing needed for outside activity may be made within the hospital itself as another project.

Furthermore patients sitting on wards for lack of regulated activity tear up and destroy thousands of dollars worth of clothing with no possible return to the hospital. Prior to the advent of industrial activity, this hospital had what was then known as a destruction list, which came to the supervisor's office each day, giving the type and the amount of destroyed articles of clothing as well as furniture. After a few years of extensive industrial therapy it was no longer necessary to maintain such a list because of the small quantities destroyed.

Tools are kept in a central room, keeping a few patients busy caring for them. The tools pay for themselves in the first year of use. A good pick and shovel have tremendous therapeutic value and pay dividends to the hospital itself.

Extra attendants are not needed. Experience has taught that it is simply a question of where the attendant is needed most. If most or all patients on certain wards go outside to work, the attendants from those wards go with them.

ENCOURAGE PARTICIPATION

From the time of admission the patient is impressed with the idea that everyone is busy doing something. After a two or three day observation period the new patient is asked by the nurse or the attendant to join in the routine activities of ward housekeeping. He is made to feel that it is good for him to pitch in and help with the general work. Normally, in about ten days, the patient will be presented at the staff meeting, after which the process of placing him on a schedule of regular industrial activity begins.

The choice of the group depends chiefly on two main characteristics: first, the amount of custodial security required; and secondly, the patient's basic personality and specific illness. There are groups suited to maximum security wherein the patient is constantly under close observation. Here there are two attendants and not more than twelve patients. The work area is chosen for its proximity to the hospital and the work itself is of such a nature that harmful tools are not used. Lawn-rolling, lawn-mowing, leaf-raking and snow-shoveling are but a few of the occupational outlets for such a group. Here it must be pointed out that experience has proved only one such group outside is needed at this hospital. Patients for whom custodial security is very important and difficult to maintain or who, for other reasons, should not go out of doors, are employed in the cafeteria and in housekeeping.

There are groups assigned to work on the farm, the garden and the cannery, the paint shop, the laundry, the green house, the grounds and flower beds. There are the craft and repair shops, garage, and other activities which permit the patient to be away from his ward.

Assignment on the basis of the patient's per-

sonality and illness is not capable of strict analysis. The physician in charge is familiar with the general therapeutic atmosphere of each group and the specific assets and limitations of each attendant. The initial assignment is made by written prescription by the physician based on his evaluation of the patient's needs.

Subsequent changes are made by the physician or the supervising occupational therapist as the patient's needs change.

MEDICAL SUPERVISION

Informal rounds are made to all units at least weekly by the physician in charge. His presence in the work area, therefore, gives patients an opportunity to approach him directly about change in assignment or other problems. These visits are stimulating to both patients and attendants by increasing the status of the work activity. By these rounds the physician is afforded an opportunity to discuss the patient's condition, in the work environment, with the therapist and the attendant who have the closest contact with the patient. The best reports and most significant observations can be obtained in this direct manner. Written reports, no matter how detailed, cannot be as successful in describing the individuality of the patient and of his work. In fact the more one relies on detailed, written reports, the more likely it is that the attendant, the doctor, and everyone else will lose sight of the commonsense goal of the industrial therapy program, which is the realistic treatment of every patient as a living human being.

A notable feature of our program is the emphasis on work as therapy, not on the patient as potential labor. The attendants supervising the patients are directly responsible to the nursing service. Before being permitted to take full responsibility of patients off the wards, they must spend a period of training as ward attendants. They are encouraged to have pride in the quality of adjustment their patients are able to make and to feel that they contribute to improvement when it occurs. To further the concept of work as therapy and the importance of social acquaintance between patient and attendant, each group spends one-half day of its regular schedule in recreation, usually ball-playing or gym work. The regular attendant escorts his own group to the recreation area and participates with them.

The goal of our industrial therapy program is threefold. Primarily we hope to improve the patient sufficiently that he may go home. If this is impossible we hope to help the patient find a truly satisfying, responsible place for himself in the hospital community. We constantly strive to improve the patient's independent work capacity so that the static patient can make the fullest possible adjustment. After long training through various levels of work therapy, many patients have become an integral part of the hospital system, performing much of its specialized work as well as routine labor. Patients do watch repair, make cement blocks, act as plumber's helpers, book binders, carpenters, cabinet makers, printers, bakers, cooks, car mechanics, brick layers and a myriad of other skilled and semi-skilled jobs. Many of these people exhibit a genuine craftmanship which is difficult to purchase with wages today. In a large mental hospital there are dozens of patients who, with thoughtful guidance, can be helped to find a position of responsibility. Such a patient is often a vital model on which newer, less adjusted patients may pattern their own behavior.

If these goals fail, we try at least to help the disturbed or agitated patient find a more level adjustment. Work utilizes much of the destructive energy of an overactive patient, and mobilizes the constricted energy of the withdrawn patient. Either symptom reduces the patient's socialization and makes him less responsive to therapy. On the men's section of this hospital with a census of 1462 we require as little as 10 to 14 sedation orders a night and need but one ward with an average census of 42 to care for disturbed patients.

SUMMARY

The industrial therapy program at Warren State Hospital is discussed and brief reference is made to the well established fact that productive occupation is invaluable therapy for mental patients both to promote recovery and to facilitate chronic adjustment. There is a discussion of a few ways jobs are created. The entire project is built on common sense and a simplicity to which even an inexperienced attendant can readily adapt. It is observed that most therapists and attendants profit more from on-the-job discussion with the physician than through written reports or formal meetings. Reducing records to a minimum, full time effort should be directed to the patient himself to understand better his needs.

The United States Civil Service Commission has announced a new examination for occupational therapy positions in hospitals, centers and regional offices of the Veterans Administration throughout the United States and Puerto Rico. The salaries range from $3,410 to $5,060 a year.

Graduation from a school of occupational therapy is required. Professional experience in occupational therapy is also required for positions paying $4,205 and above. No written test will be given.

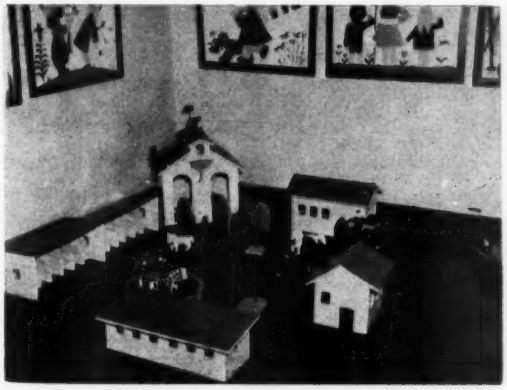
Application forms may be secured at many post offices throughout the country or from the U. S. Civil Service Commission, Washington 25, D.C. Applications will be accepted until further notice.

GROUP PROJECTS WITH PSYCHIATRIC PATIENTS

CORINNE V. WHITE, O.T.R.[1]

In a previous position as a staff therapist in a large psychiatric hospital, I found myself in a situation not unlike that which I am sure is prevalent in many larger hospitals. Our problem was the chronic one of too few therapists to adequately administer occupational therapy to the patients on an individual basis. There was the added problem of working with patients who were too acutely ill to realize any incentive or purpose for the projects or work they might want to do. Consequently it was felt that there was a definite need for some simplified, repetitive activity which could readily include large groups of patients.

Christmas being conveniently near, a plan for making decorations for the tree, with an accompanying garden around the foot of the tree for added interest, was considered. The idea of making a small wooden circus was evolved, this to be presented to a children's hospital when completed.



Seeing this multiple-item project assembled and used as a Christmas decoration encouraged further group activity.

The project was begun by sorting patients into general groups and grading them according to their potential abilities at that time. For example: those who were incapable of complicated work or sustained interest were dealt with step by step. They were first given toy animals traced on ½ inch pine to be cut with a coping saw. Later they were asked to file and sand these and finally paint them. Others whom it was thought might possibly be able to follow through on an individual or even a two-man job were asked to saw (with an electric jig), construct and paint horse stalls, circus ring, circus wagons and a large barn. A number who were generally out of contact and who could not retain any interest were given sanding projects, work on pickets for the little fence, or the painting of pine cones, spools and empty weaving cones to be used as tree ornaments.

When most of the articles were completed, a few of the better patients were asked to help the therapist trim the tree and assemble the circus. As the group entered the shop at the beginning of the next period it was gratifying and encouraging to see the interest shown by even the most acutely ill. An intangible and contagious group feeling seemed to develop from the completion of the project. Soon after this a new project was begun. This one was providing furniture, and various toys for a nursery room to be used by the visitor's children, as children were not permitted to visit patients on the wards.

A second project requiring group cooperation was the furnishing and decoration of a nursery for visitors' children.

Small substantial tables and chairs were cut out by hand of oak flooring which had been stored around the hospital unused. These were painted bright colors, not only to make them appeal to the children using them but also to provide stimulation for the patients making them. A set of 12 large pictures using plywood cut-out figures mounted on bristol board were made for the wall decoration depicting the months of the year. This provided additional cutting, sanding and painting. Toys such as trains, wooden autos, pottery dishes, a set of blocks and a kiddie car were constructed.

It was found on analyzing the project that many who began in the group doing the very simple projects stepped into the moderately difficult class, while some of those who had not been able to sustain an interest seemed able to complete individual projects, working step-by-step, comprehending what their results should be. Many of the "chronic sitters" were drawn into sanding

(*Continued on page 270*)

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HIGHER EDUCATION FOR THE CEREBRAL PALSIED

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United Cerebral Palsy Association, Inc.

One intensive study of the employability of adults with cerebral palsy[1] seems to indicate that the college graduate who is cerebral palsied finds work only below the levels of his skills and training. The resultant frustrations and psychological handicaps ascribed generally to these individuals have had a tendency to influence the vocational and educational planning of others with this condition who contemplate higher education. Most students have begun to veer away from a college education, with all its concomitant advantages, and some counselors have agreed with this advice because many of the present-day graduates have not been able to use their education as a means of livelihood. The fact that many non-handicapped individuals do not earn their living in the direct area of their major studies seems to be forgotten, or the thought shunted to a siding.

Nevertheless, the cerebral palsied high school graduate should be given the opportunity for collegiate education provided three questions are kept constantly in mind and answered when the problem presents itself to the young person, his family, and the counselor:

1. If this individual were not handicapped, would he be college material?
2. Will collegiate education be a subterfuge that is presented merely to prolong the interval until the cerebral palsied person will have to meet the competitive world?
3. Should not guidance activities that direct an individual toward college be accompanied with modest vocational goals?

It is evident from this study that in the foreground of counseling in the high school years the presentation of realistic objectives should become part of the counseling process. These objectives should accompany exposure to the advantages and opportunities for self realization and the widening horizons that accompany collegiate training. College experiences should not be prohibited because the individual is neurologically handicapped.

Many adults with cerebral palsy report unhappiness because they cannot use their training vocationally. This seems to indicate that college education was improperly suggested and the inference is to be drawn that guidance services were inadequate or incomplete. Counseling should have been better correlated with physical ability and individual desire, and modest employment goals more susceptible of achievement should have been suggested.

There is no doubt among those who meet the adolescent or the adult with cerebral palsy that satisfactory adjustments may be made if there is adequate utilization of all the information available about the individual and, if existing resources and referral agencies are exploited to their maximum and, if as a result of skilled interviewing and adequate counseling, some cerebral palsied students who are college trained are prepared for competitive employment, some for success in a sheltered workshop situation, and some for rewarding home activities.

The proper goal should be determined and higher education planned in the light of its values for the whole individual. Guidance must lean toward achievement, toward an optimum degree of vocational skill and independence and toward a satisfactory program of educational growth. Decisions must be based upon the emotional adjustment, status and potentiality of the patient. It must be remembered that the most encouraging aspect of placement at the present time is the increasing tendency to match jobs with physical capacities.

Job descriptions are appearing that are based upon physical demands related to physical disabilities. As more analyses of this type are made, more jobs will be available to the disabled; and the cultural program extended in line with his needs and desires. Realistic evaluation is the keynote, but evaluation unaccompanied by insight into personality structure and personal desire merely creates resistive attitudes.

It is simple to inform a person that his vocational goals are unrealistic—often they are, as the above-mentioned survey disclosed. What is difficult and unavoidably necessary, is skillful redirection so that vocational aim and probability of success are reconcilable and attainable. Although handicapped individuals exhibit a tendency to extend the fantasies of immaturity in occupational choices, have difficulty in relating with others and in forming satisfactory social and emotional adjustments, there is no reason to believe that greater adjustability cannot come about as a result of high calibre counseling. What is wanted, therefore, is a definition of this type of counseling.

A series of guiding principles is presented, showing the activities which the individual with

(*Continued on page 267*)

1. Glick, Selma J. and others: *Employment Experiences of 200 Cerebral Palsied Adults Who Reside in New York City*. United Cerebral Palsy of New York City, Inc., Sept., 1953.

Apparatus Aids

ADAPTED EQUIPMENT FOR A SEVERELY INVOLVED POLIOMYELITIS PATIENT*

VIOLA W. SVENSSON, O.T.R.
MIRIAM C. BRENNAN, O.T.R.

FEEDING AND WASHING

A closeup of a turntable used for feeding is pictured in Figure 1. The patient can push food against the attachment shown, in order to secure it on the fork. The hand equipment holding the fork was previously made for the patient before admission to this hospital and has been adapted for use with a swivel mechanism which was made in the occupational therapy department. Though we are now able to make these turntable mechanisms with basic uniformity, the problem of placement must be adapted to the use of each patient whether the mechanism is used with or without the locking device, the plastic wall and the eating utensil attached to the slings at an accurate degree of balance.

Figure 1

The functional utilization of the setup is shown in Figure 2. The patient is now able to feed herself completely independently except for the cutting of meat.

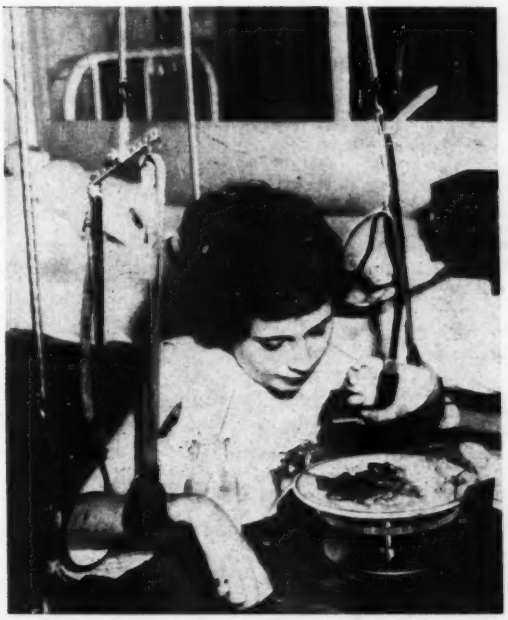


Figure 2

Due to limitation of patient's abilities to accomplish a large scope of daily activities, a few attempts have been made that have been successful to a certain degree of personal satisfaction to the patient. Figures 3 and 4 show a setup which enables the patient to wash her face. A sponge is slipped onto the back of her hand and by dipping the hand into the water and brushing against the

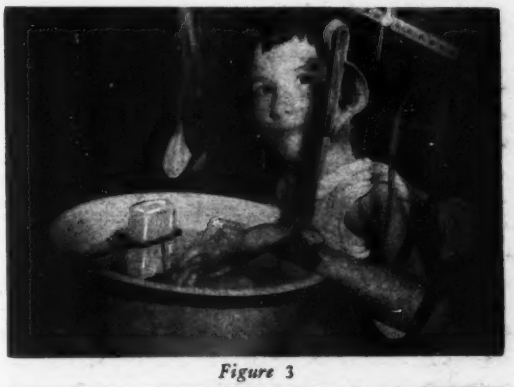


Figure 3

*This is the fifth of a series of illustrations of apparatus aids toward independent activities as designed and constructed in the occupational therapy department of the New York State Rehabilitation Hospital, West Haverstraw, N.Y.

Figure 4

soap and bending her head to meet the sponge, she accomplishes the act. Drying is achieved by a turkish mitt put onto her hand, and by bending her head forward she is able to dry her face thoroughly.

TYPING

To enlarge possible abilities for future use, typing has been attempted by a stick controlled in her mouth. Figure 5 shows the method of picking up stick, Figure 6 shows the utilization of it in typing. This allows her to type, but she is still dependent, of course, on someone to put in

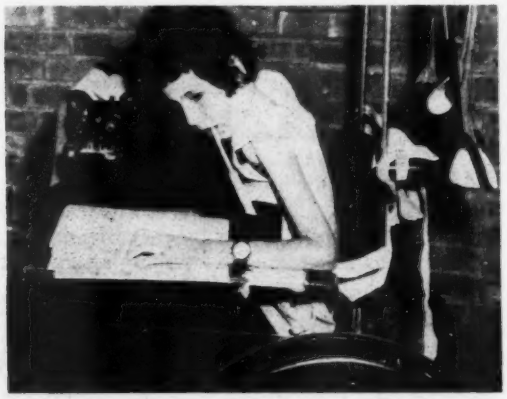


Figure 5

and take out paper, move carriage, etc. She is able, with the use of slings and hand holder with a stick in the slot, to type on an electric typewriter.

With this same special hand attachment holding a stencil brush and the utilization of suspension slings, the patient is able to stencil after material has been set up as shown in Figure 7. This is one craft activity the patient is able to do to any extent which gives her some sense of accomplishment, though most of the preparation and setting up must be done by the therapist. Most of her activities are carried on by her wrist flexors and

Figure 6

neck flexors. The freely moving and well-balanced spring suspension slings give her an enlarging scope of movement to accomplish these activities, and are opening wider possibilities of motion that give her enjoyment in creating play activities which she is now discovering.

Figure 7

RECREATIONAL ACTIVITY IN CARD PLAYING WITH MOUTH PINCERS

Figures 8 and 9 show pincers as designed and constructed in the occupational therapy department for this particular patient; however, it is

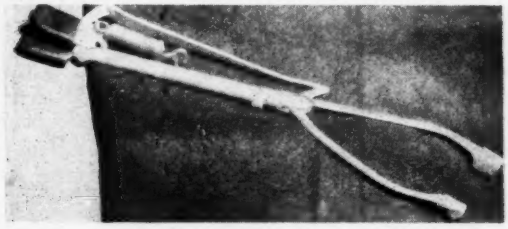


Figure 8

possible, with variations, to utilize pincers for other patients according to their individual problems. Both the mouth pieces and the tips are covered with rubber. When the patient bites

down, the pincer closes. Its principal use is for picking up and releasing without any prolonged holding.

Figures 10 through 12 depict the series of motions required to bring a card from the table into the slot in the specially made board to hold cards. The ramp is made from an aluminum sheet.

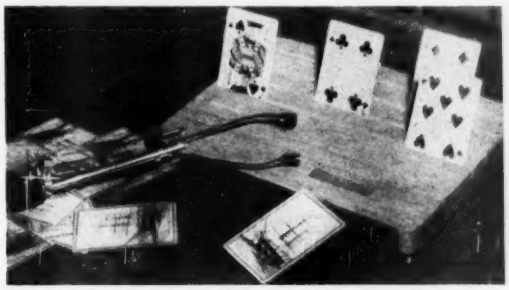


Figure 9

The first step, Figure 10, shows the method of obtaining the mouth pincers from a jar to begin playing with cards.

Figure 11 shows the method of picking up a card and sliding the card from the table up the aluminum ramp to the slot in the card board. The card is then dexterously tipped into the slot.

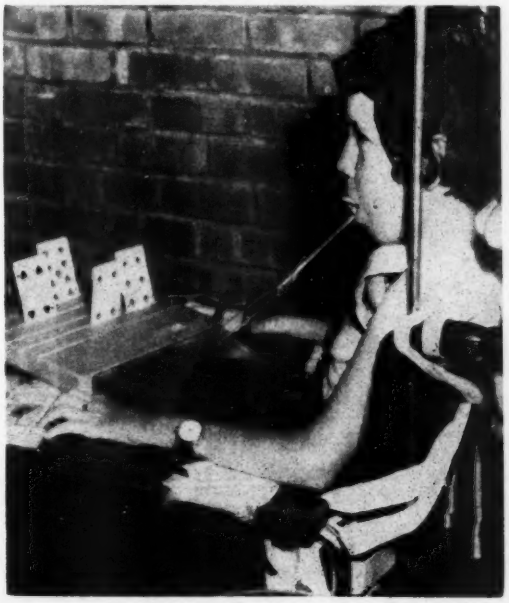


Figure 10

Figure 12 shows the utilization of the wide area of the pincer in picking up a card and controlling it while dropping it into a small slot so the card can be seen for playing the game.

These activities are but a few for this patient—but have stimulated her imagination in utilizing the adapted equipment that we have made for her

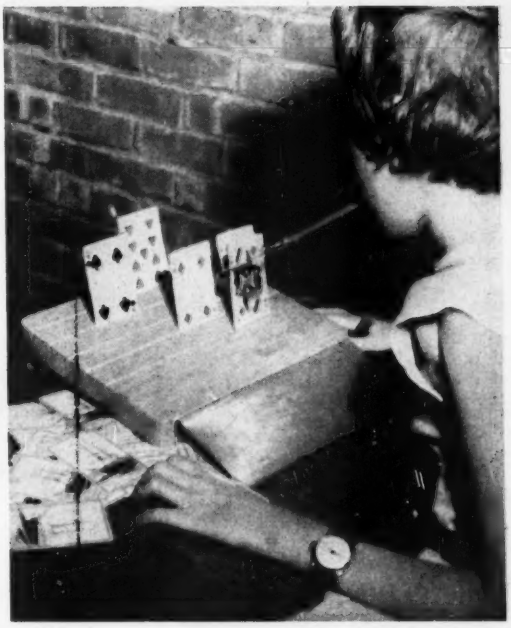


Figure 11

to develop some abilities in her daily living. She is able to play cards successfully with other patients in this manner. She is quite speedy—having learned excellent coordination and is very adept with this pincer in her mouth. It must be kept in mind that a patient so completely involved as pictured is dependent at one stage or another in all her activities on a person to set up material or equipment for her to reach and use. Yet the activities accomplished as shown and others being currently attempted are sufficiently important to the individual's outlook on life so that when finally discharged she carried on those special abilities as taught here.

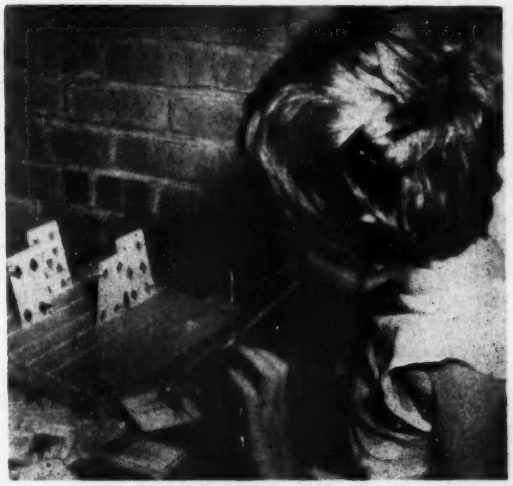
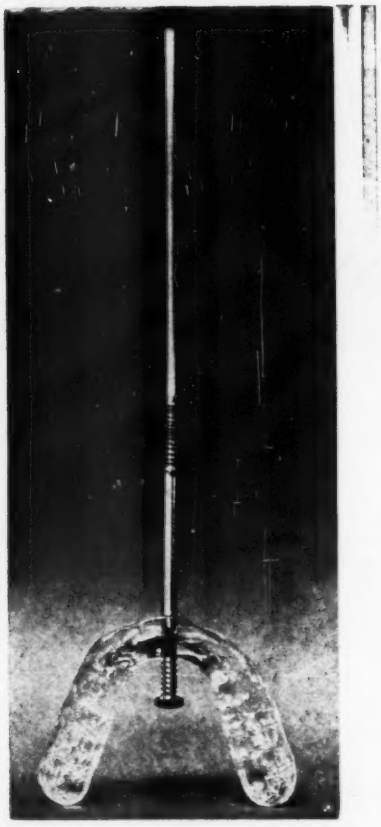


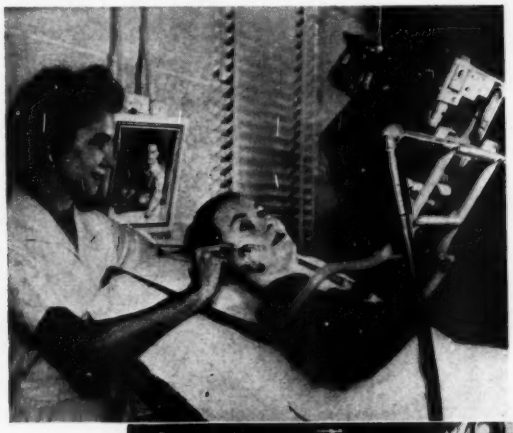
Figure 12

DEVICE FOR TYPING WITH A MOUTHPIECE WHILE ROCKING ON A ROCKING BED

JEAN LINDSAY BERRY, O.T.R.

Central Carolina Convalescent Hospital
Greensboro, North Carolina





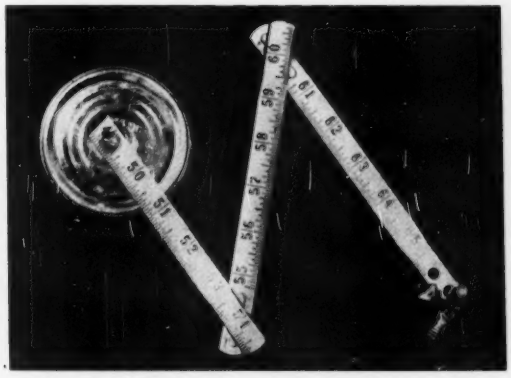
An electric typewriter is bolted with stove bolts to a frame made of ¾ inch galvanized pipe. This frame extends far enough on each side to clear the patient and then extends to the head of the bed so that it rests on the mattress from the shoulder level to the head of the bed. It is strapped to the frame of the bed across the end of the mattress to give stability and also as a safety precaution. The angles of the frame are determined by the position of the patient and the degree to which the head is elevated.

The mouthpiece has two distinct parts. The plexiglass part was molded by a dentist so that the patient's top and bottom teeth fit snugly into the plexiglass. This makes it possible for the patient to swallow and talk while holding the mouthpiece with her teeth. The metal tube that extends from the mouthpiece is made of stainless steel tubing. The tubing is attached through the mouthpiece and placed at the angle that suits the patient's need. The length of the tube depends upon the position of the patient and the typewriter. The one shown is about 8 inches long. The photograph shows that the tube extends into the mouth about ½ inch to allow the patient to extend the tube to reach the two top rows of keys. This extension is made possible by having a small spring attached to the tube and the tube inserted into a larger tube. We have now eliminated the second spring shown in the photograph of the mouthpiece because of the moisture in the mouth. The spring connecting the two tubes is sufficient. The rubber tip on the end of the tube makes typing easier.

A WRITING AID

Nona Toops

This writing aid is designed to enable patients such as those with cerebral palsy, amputees, and nerve injuries who are handicapped in their dominant hand, to write more easily. This simple apparatus holds the pencil in writing position at all times regardless of the strength of grasp, while the non-dominant hand supports the base or moves it about.



Construction: A small tin can, three sections of an old folding ruler, and a hair wave clip are fastened together by screws to make this device. The metal on the folding ruler joints is filed down to make easier rotation possible. A clamp may be installed to hold the base to a drawing board if the non-dominant hand is incapacitated, or to clamp down the base while both hands exercise at once with a folding arm on each side.

OPPORTUNITIES

Today no one need wish for an education if he is intelligent, sincere and conscientious. Some wish for an advanced education without realizing that such an aim is within their reach through scholarship awards. Undergraduates may write to the school of their choice (see list of schools on page 269) for information. Now is the time to plan for college entrance next year.

Practicing occupational therapists may take advantage of the many scholarship awards that offer advanced courses in special fields, some carrying college credit. Some of these offers that were announced during the past year are listed below. For details for 1954 write AOTA or the specific institution listed. Also listed are some excellent seminars or institutes held during the past year open to occupational therapists.

Remember, in America it only takes initiative and work to advance — the opportunities are to be had for the asking.

Postgraduate Course in Cerebral Palsy
Coordinating Council for Cerebral Palsy
270 Park Avenue, New York 17

Treatment of Poliomyelitis
Georgia Warm Springs Foundation
Warm Springs, Ga.
(Three to six month course. Scholarships available from N.F.I.P.)

Kenfield Memorial Scholarship
American Hearing Society
c/o Miss Rose Feilbach
1157 N. Columbus St.
Arlington, Va.

National Tuberculosis Association Fellowships
National Tuberculosis Assoc.
1790 Broadway, New York 19

Picturecraft Scholarships
American Occupational Therapy Assoc.
333 West 42 St., New York 36

Workshop on Poliomyelitis
University of Southern California
Los Angeles, Calif.
(Scholarships available from N.F.I.P. College credit)

* * * *

Conference on Aging
Division of Gerontology
University of Michigan
1510 Rackham Bldg.
Ann Arbor, Mich.

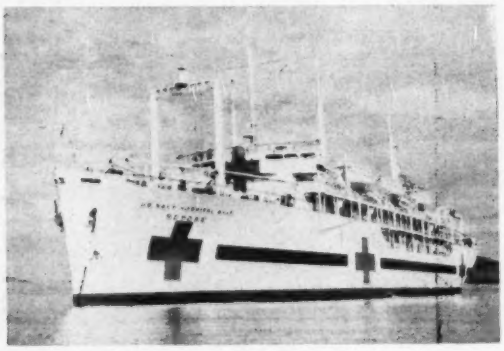
Institute on Rheumatic Fever
La Rabida Sanitarium
East 65 St. & South Shore Dr.
Chicago 49, Ill.

Instruction Seminar
American Congress of P. M. & R.
30 N. Michigan Ave., Chicago 2

Mental Hospital Institute
American Psychiatric Assoc.
Mental Hospital Service
1785 Massachusetts Ave., N.W.
Washington, D.C.

Guests of the Navy--

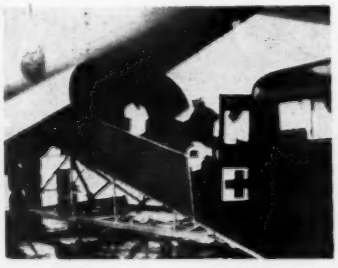
A few of the photographs the Navy sent Miss McNary as souvenirs of her trip to Hawaii. Details of the trip were carried in Miss McNary's column "From the President" in the July-August, 1953, issue of the American Journal of Occupational Therapy, page 171. In the photograph, upper right, the guests (*left to right*) are: (*front row*) LCDR Kathleen Zeigler, Escort Officer; Dr. Minnie Moffett, M.D., Dallas; Mary Nesbitt, Supervising Physical Therapist, Massachusetts General Hospital; Henrietta McNary, AOTA President; Mrs. Lorene W. Ingalls, Women's Board, Chicago Presbyterian Hospital; Lt. Gen. Franklin Hart; Mrs. Elliott Donnelly, Auxiliary Board, Children's Memorial Hospital of Chicago; Betty Ross, National Broadcasting Company, Chicago; (*back row*) Mrs. George Ranney, Member of the Board, Chicago Lying-In Hospital; (*partially hidden*) Mildred Lorentz, Director of Nurses, Michael Reese Hospital, Chicago; Dorothy Gebauer, Dean of Women, U. of Texas; Lena Clauve, Dean of Women, U. of New Mexico; Mrs. Margaret W. Carr, Auxiliary Board, Children's Memorial Hospital of Chicago; Mrs. R. Max Brooks, Women's Advisory Defense Council of Austin; Elizabeth Moran, Director of Nursing, Henry Ford Hospital, Detroit.



The ship REPOSE that took *the group of fourteen women from the mainland to Hawaii. It is a floating hospital and was returning to duty in Korea.*

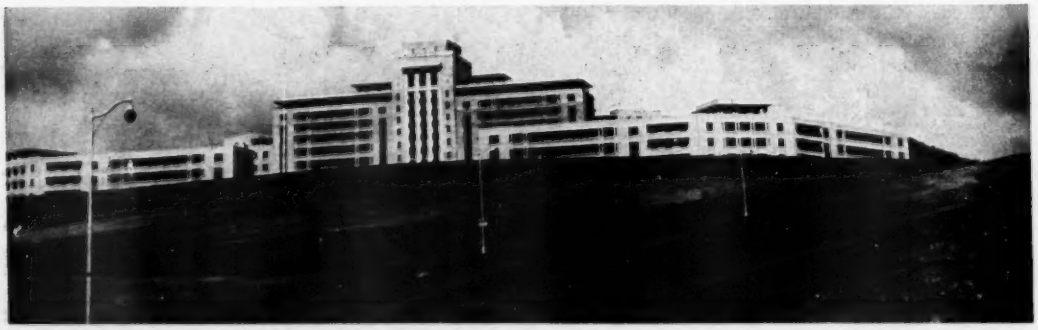
The group assembled with Lt. Gen. Franklin Hart, USMC, at his Pearl Harbor headquarters after a demonstration by the Marine Drum and Bugle Corps.

Aerial ambulance on the deck of the REPOSE. *This was a demonstration and the "patient" was a volunteer from the crew.*



Korean veterans returned by air evacuation which provides quick transportation of the wounded.

Arriving from a morning cruise on the USS BUGARA, *one of the two submarines which took the group on a demonstration run*



Standing majestically on a hilltop overlooking the Pacific, the modern Tripler Army Hospital serves returning veterans injured in conflict and Armed Forces personnel in the Hawaiian area. The coordination of all military services is graphically demonstrated through the Army and Navy medical staff.

NATIONALLY SPEAKING

From the President

Occupational therapy was asked to take its place in the "Story of Medicine in Art," an exhibit that was local but whose significance was broad indeed.

Under the co-sponsorship of the State Medical Society of Wisconsin and the Medical Society of Milwaukee County, the Milwaukee Art Institute assembled a unique exhibit. Housed in two buildings were over a thousand entries, some of them rare and expensive, including paintings, prints, sculpture and ceramics. Collected from across the country, they depicted the long story of the development of the science and practice of medicine. A program of lectures with slides and movies attracted many visitors, especially physicians and medically allied personnel. Comment was excellent.

Many communities have good exhibits, I am sure. This one reached print in this column because of its obvious, as well as inferred significance.

In conjunction with the "Story of Medicine in Art," occupational therapy was asked to provide the special exhibit which accompanies each of the regular shows and hangs in the interpretational gallery of the Art Institute. "Art in Occupational Therapy" showed paintings, drawings and other art media actually used in the treatment of patients. The material was collected from the clinical training centers associated with the student occupational therapy program at Milwaukee-Downer College. The quality and interpretational value of the entries was excellent. Nineteen different occupational therapy centers contributed so much fine material that some had to be hung in an auxiliary exhibit at the College. Part of the exhibit was sent to the conference of the American Occupational Therapy Association at Houston following the showing in Milwaukee.

Medicine from pre-Christian times to the present represents many great minds and the gradual growth of concept. It is a quiet tribute to the spirit and effectiveness of occupational therapy to be associated so significantly with this panorama.

Laity and professional personnel read with care the descriptive material explaining non-verbal expressions in art, children's selfportraits, the gain of motor control, projective techniques, notion of mobiles and symbols of tensions all represented in drawings and paintings. It was graphic storytelling to them. People are ready to hear the story, people are grasping the concept of occupational therapy much better. People are understanding the use of various media as a means of helping a patient to feel, move and think with therapeutic significance. The artistic quality of the work interested people much less than the idea it expressed or represented. People took time to read the fine print.

Occupational therapy should feel proud of the invitation to participate and the interest given the exhibit as it hung. A local television show, newspaper publicity and mimeographed material at the exhibit evoked comment and question: "How does one become an occupational therapist?" Oldsters regretted the oversight in their earlier years. Opportunities, such as these exhibits, motivate our recruitment endeavors.

The recruitment value of all such exhibits or similar demonstration of other media is high when the patient-value or the man-purpose of it relates to medicine. People in general have a more realistic understanding of occupational therapy and seem more susceptible to interest in the field. When they hear of the opportunities that stand open they realize that the professional potentials are high. Let us make the most of such occasions in all local areas. Let us coordinate recruitment efforts with each public showing and stimulate the opportunities for associated presentations with other significant endeavors. Let us press our recruitment program to fill those openings with highly qualified occupational therapists. The "Story of Medicine in Art" has many channels; may one become a pathway for new personnel in occupational therapy.

Henrietta McNary, O.T.R.
President

From the Executive Director

I am glad to use this opportunity to report to you regarding my recent brief visit to Puerto Rico upon the invitation of the State Insurance Fund of which Mr. G. Atiles Moreu is the manager and Dr. Harold D. Storms is the Director of the Rehabilitation Clinic. The primary purpose of this visit was to observe the newly established School of Physical and Occupational Therapy being developed by the State Insurance Fund and now starting its third year as a combined course, with a present enrollment of thirty men and women students.

First let me give you a bit of the setting of which this professional training is a part. You know that Puerto Rico is a lovely tropical island approximately the size of Connecticut with a population of 2,300,000 people. Originally completely agricultural, there has been in the last few years a marked increase in industrial activity, some 225

business concerns having established operating plants and factories on the island. This has resulted in an increased necessity for rehabilitation of the industrially injured workman and has probably been somewhat responsible for the impetus resulting in the excellently planned health programs and clinical facilities evidenced in the total rehabilitation programs of the island.

The over-all impression gained was that of a steadily developing medical and health service now being more adequately rendered than ever before due to the increasing number of trained personnel available, both doctors and ancillary therapists—occupational, physical, speech. The nucleus of this personnel are the physicians and therapists who have come to the United States through the past years for their professional education and returned to Puerto Rico to build programs of medical treatment and care. Much of this educational plan has been made possible through the scholarships awarded by the State Insurance Fund. Provision for a steadily increasing force of local personnel is now being accounted for through the establishment of the Medical School of the University of Puerto Rico and the School of Physical and Occupational Therapy under sponsorship of the State Insurance Fund, both programs of which are being designed to meet the standards of the American Medical Association, Council on Medical Education and Hospitals.

Mention of a few of the hospitals which I had the opportunity to visit in connection with the clinical training program of the school will illustrate the cross-section of the medical treatment facilities available, each with a well developed department of occupational and physical therapy or one which was being initiated: Cerebral Palsy Clinic under the Department of Health, Ruiz Solar Sanatorium (including a 200 bed pediatric tuberculosis section), Bayamon District Hospital (general medical and surgical), Maldonado Psychiatry and Tuberculosis Hospital, Rodriguez Army Hospital, Physical Medicine and Rehabilitation Clinic. These institutions, federal, insular and private, represent the usual diagnostic index of human diseases and disabilities, as well as health problems peculiar to the island and its living conditions. I believe many of us have followed the famous School of Tropical Medicine and its fascinating research studies which has been located in Puerto Rico for a number of years.

The Rehabilitation Clinic, located in San Juan, the Capital City, is one of several physical medicine clinics including two as special surgical centers, maintained by the State Insurance Fund and can well be designated as the pilot program. The case load here covers a wide range of physical injuries due to industrial accidents about 50 per cent of which are among sugar cane workers who have been injured while wielding the "machette." The purpose of the occupational therapy program is four fold: 1) to provide rest, under control, 2) to increase muscle strength, 3) to build up morale, 4) to test work ability. Techniques and graded programs are quite similar to much of our work in the States. A final work test shop determines if the patient has received the maximum treatment in physical medicine before returning to his former work.

The School of Physical and Occupational Therapy is under the medical direction of Dr. Harold Storms and represents a plan of dual training which does not yet exist in the United States but which is undergoing "experiment" in both Canada and Australia. As stated above, the curriculum is patterned on the theoretical, technical and clinical requirements of the American Medical Association Essentials of an Acceptable School for each of the two fields represented. The course, with a prerequisite of two years of college, covers a total of three full calendar years, with the clinical work, under trained supervision, running concurrently throughout, beginning in the second semester of the first year. The lecturing faculty is comprised of prominent doctors from the clinic staff, local hospitals and from the University of Puerto Rico. The School has two full time supervisors, one each in physical and occupational therapy, respectively. Occupying several floors with the rehabilitation clinic in the Professional Building, which also houses a hospital, the School has immediately available excellent clinical facilities for teaching and training.

The development of this school will be watched with genuine interest as the first group of graduates completes the prescribed program in respect to meeting the test of practical and technical demands in the field for personnel dually trained. Increased knowledge of the rehabilitation field and desire of young Puerto Ricans to train in occupational and physical therapy is evidenced by the enrollment of the incoming class which is tripled in number over last year. Another potential development of the school is the interest evinced in possible affiliation with the medical school of the University of Puerto Rico. This would follow the pattern recommended for all new schools of occupational therapy.

It was a pleasure to attend a delightful dinner meeting which the members of the Puerto Rico Occupational Therapy Association arranged with 18 registered therapists present plus several of the doctors and Insurance Fund representatives with their wives. This is one of our newer associations having petitioned and been seated in the House of Delegates in 1951. It is good to note the trend toward graduate study which leaders in the association are undertaking. A master's degree in occu-

pational therapy is held by Esteban Lopez-Fernandez, president, and Carmen Perez, treasurer (also O.T. supervisor in the school) and Rosa Jorge, delegate to the 1952 conference in Milwaukee (currently studying). The association holds regular program meetings and has taken an active part in recruitment and publicity on the island as well as encouraging high standards for civil service qualifications and salary scales for occupational therapists.

This brief summary points to another stepping stone of progress along the rehabilitation road outside of the continental United States. The ability and breadth of vision on the part of the State Insurance Fund in the development of this unique program is a good example of a self-help plan. It is not only answering the more immediate needs for personnel in the State Fund set-up but is beginning to serve the whole of Puerto Rico in a more comprehensive scheme designed to help meet health needs and problems. Furthermore, because of geographical location and language, it holds portent of fulfilling an important role in the extension of modern rehabilitation methods into the vast area of Latin-American countries. Already, Puerto Rico is serving in the Point Four Plan.

I would like to refer readers to the following articles which give a more detailed picture of what I have high-lighted in this column:

Storms, Harold D., M.D. "Industrial Rehabilitation in Puerto Rico," *Bulletin of the American Rehabilitation Committee*, Vol. L, No. 5, March, 1953.

"Industrial Rehabilitation," *The Physical Therapy Review*, Vol. 31, No. 9, Sept., 1951.

Lopez-Fernandez, E., O.T.R., "The Work Test," *Organo Del Fondo Del Seguro Del Estado*, Vol. I, No. 1, July, 1952.

deCoss, Blanche P., O.T.R., "Delegates Report from Puerto Rico," *American Journal of Occupational Therapy*, Vol. VII, No. 2, April, 1953.

Marjorie Fish, O.T.R.
Executive Director

From the Educational Secretary

The education office takes pleasure in announcing the following as having passed the June, 1953, registration examination of the American Occupational Therapy Association:

Ackell, Constance Kelly, 1
Ahrens, Elizabeth E., 8
Amberson, Margaret M., 14
Anderson, Catherine G., 23
Anderson, Ruth H., 23
Bannas, Elizabeth, 7
Bates, Darlene J., 8
Becka, Loretta H., 3
Beckwith, Constance S., 16
Bemus, Stella J., 26
Berryman, Nancy D., 23
Best, Mary Ann, 14
Biener, Margaret E., 6
Blagbrought, Joan McK., 1
Bonnett, Helen L., 24
Borden, Lessye V., 16
Brown, Diantha B., 14
Burnham, Joanne M., 1
Calef, Patricia Lee, 11
Campbell, Joyce C., 23
Cardarelle, Dixie J., 9
Carlson, Joan Helene, 9
Chaplin, Virginia, 7
Coffin, Jean L., 11
Collins, Helen C., 1
Crystal, Jerome, 12
Dahlstrom, Helen, 2
Dankenbring, Mary Basye, 22
Dawson, Nancy Givens, 22
Deans, Barbara Helen, 11
deLeeuw, Carolina F., 8
Dockum, Barbara Ellen, 11
Dooley, Audrey A., 15
Dorbandt, Barbara, 18
Dose, Mildred B., 23
Drussell, Ruth D., 9
Dufford, Jenny C., 24
Eddy, Eloise H., 18
Egan, Doris Jeanne, 19
Eilts, Norma J., 9
Etter,* Mildred Field, 26
Evans, Margaret Ann, 1
Evans, Wanda H., 22
Faulkner, Jane Norris, 1
Fieldman, Estelle Mona, 1
Fine, Beatrice, 22
Flood, Claire M., 1
Ford, Ralph Everett, 9
Fowler, Eloise Janet, 19
Frankl, Edith Ida, 12
Freeman, Patricia G., 24
Frieders, Arlyn, 8
Fukuda, Mary Aiko, 8
Fung, Martha, 3
Gibbs, Juanita L., 18
Glass, Robert P., 15
Goldberg, Gloria, 8
Gray, Elizabeth S., 4
Grunewald, Cordia B., 22
Hafendorfer, Anne Martin, 22
Hall, Ruth B., 8
Hammel, Dawn V., 18
Hansen, Beverly J., 15
Hansen, Jeanne L., 18
Hatch, Barbara D., 18
Hayes, Irene Terese, 1
Heckl, Teresa M., 8
Henry, Katharine S., 22
Hero, Virginia L., 11
Herring, Marjorie B., 8
Hickey, Dorothy Dustin, 1
Hill, Helen M., 18
Hill, Mary Ellen, 1
Hoan, Mildred Ing, 2
Hooke, Sylvia M., 14
Hopponen, Joy, 9
Houdek, Kathryn V., 4
Hubbard, Sally Ann, 8
Hughes, Mary T., 12
Hulse, Robert H., 16
Hustad, Carole Hope, 9
Inouye, Helen H., 22
Irving, Joan, 18
Jarke, Ruth, 8
Johnson, Lenore, 25
Johnson, Mary Ann, 9
Johnston, H. Joanne, 5
Jorgensen, Janis M., 8
Juten, Beverly Ann, 9
Keleske, Dolores P., 10
Keller*, Elizabeth A., 14
King, Jane, 8
Knudson, Lois Marie, 23
Konugres, Beverly Mae, 19
Kreyling, Muriel A., 22
Kubovich, Irene R., 4
LaBeau, Constance M., 17
Laskin, Nancy, 1
Lavis, Mary Ann, 22
Lensing, William H., 22
LeRoux, JoAnn J., 23
Levine, Clarissa Hilda, 12
Lewin, Alpha Lewis, 26
Lewis, Barbara J., 6
Lind, Amy Inez, 120
Linden, Eleanor Jean, 4
Lowe, Beverly J., 23
Lum, Leonora S. U., 8
Mabry, Patricia A., 16
MacDonald, Joanne C., 1
Marshall, Beverly A., 16
Mateny, Clotilda M., 4
Mattson, Joan Dorothy, 9
McCormack, Mary Eileen, 10
McCready, Janith Rae, 19
McDonald, Dorothy, 2
McGregor, Constance, 2
McMartin, Betty Jane, 26
McNair, Edith W., 14
Menchel, Jerome, 16
Messinger, Rosalie T., 15
Mowll, Barbara H., 14
Murphy, Eileen P., 12
Nagorka, Roman, 16
Nelson, Alice W., 16
Nelson, Jean Margaret, 9
Newhall, Mary, 1
Nicholson, Joan Helen, 8
Nill, Hildegarde K., 4
Nye, Verda Bonita, 5
O'Brien, Nancy A., 16
Ochs, Winona L., 14
Odhner*, Fred E., 14
Osgood, Shirley M., 19
Papineau, Ruth A., 18
Parmenter, Carolyn L., 14
Pearson, Dorothy V., 18
Pearson, Esther, 14
Peterson, Priscilla J., 23
Pettibone, Alice B., 26
Pierson, Mary Edith, 16
Plumley, Margaret E., 1
Powell, Helen M., 26
Pratt, Elizabeth J., 16
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Rabanal, Andrea A., 8
Rankin, Rosalie W., 1
Raymond, Beulah S., 1
Reader, Joyce Elaine, 1
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Riviere, Jeanne Mary, 15
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Robertson, Patricia A., 8
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Schuster, Leah N., 4
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Seda, Aida, 2
Seleen, Vivian I., 25
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Sewell, Marvis E., 18
Slaughter, Shula W., 19
Smalley, Caroline A., 11
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Soiland, Aud Motzfeldt, 5
Stacy, Barbara, 2
Stark, Mary Ann, 8

Steinke, Norma Jean, 9
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Tanaka, Kiyoko M., 18
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Varney, Marcia Jean, 23
Verba, Dolores D., 26
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Watkins, Harry L., 16
Webster, Nancy E., 11
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Westlund, Kenneth A., 19
Whetzal, Joyce, 24
White, Elizabeth, 14
Whitford, Dorothy E., 5
Wikstrom, June G., 11
Williams, Elaine B., 4
Williams, Greta S., 18
Williams, Lela A., 4
Williams, Neoma, 18
Wilson, Frances H., 2
Wirtz, Janie Longenecker, 23
Yarish, Anne H., 1
Zack, Gloria T., 2
*Completed with honors

CODE NUMBERS FOR OCCUPATIONAL THERAPY SCHOOLS

Boston School of Occupational Therapy, in affiliation with Tufts College	1
Colorado A & M College	24
Columbia University	2
Illinois, University of	3
Iowa, The State University of	25
Kalamazoo School of Occupational Therapy, Western Michigan College of Education	4
Kansas, University of	5
Michigan State Normal College	6
Mills College	7
Milwaukee-Downer College	8
Minnesota, University of	9
Mount Mary College	10
New Hampshire, University of	11
New York University	12
Philadelphia School of Occupational Therapy, University of Pennsylvania	14
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Martha E. Matthews, O.T.R.
Educational Secretary

EDITORIAL

THANK YOU, TEXAS

The paradox known as Texas has been ridiculed, praised, indulged but seldom ignored. It has been the center of controversy for loyalists, politicians and weather contenders. Therefore when the annual conference of occupational therapists was scheduled for that enigmatic portion of the United States, everyone hoped to be able to attend to decide for himself the value of the exhortations. Many of us were able to realize our plans and fortunate we were indeed.

Regardless of the rest of the Texas people, occupational therapists are ready to salaam to our own group which is truly representative of all parts of Texas.

TOTA presented an inspiring, challenging conference. The local occupational therapists were able to corral a group of speakers that enthused us with the challenge of our future, that inspired us with a review of our perspectives and gave us goals toward which we all will strive.

In true Texas fashion, however, this instructional inspiration was served with a liberal dash of humor and alternated with fun and diversion to make the stay in Texas a memorable one. The eyes of AOTA were upon TOTA and never did they shine more brightly.

Letters to the Editor

To The Editor:

I read with interest Dr. Dunton's editorial entitled *Terminology* in the July-August, 1953 A.J.O.T., volume VII, number 4. Dr. Dunton's presentation in behalf of the term "occupational" therapy was clear and concise, and no therapist can doubt the all inclusiveness of the term. To try to think of a term in our present vocabulary which better describes what I define as "the scientific application of graded prescribed activities to help hasten recovery from disease or injury, or the habilitation therefrom," i.e. occupational therapy, is, to say the least, extremely difficult. For there is at present no single word which describes as well what occupational therapists are practicing as does "occupational" therapy. However we should not let the matter rest here, for the term does have some serious drawbacks and if is possible to use another term which more accurately describes what we are attempting to do we should adopt it.

When you ask the layman what he thinks occupational therapy is, he will as a rule give you one of two popular responses. He will either tell you it has something to do with using vocations for their therapeutic value, or that it is therapy used to occupy time. The former of these two comes closest to the derivation of the term "occupational" therapy. For when Mr. George E. Barton advanced the term "occupational therapy" back in World War I, the occupational therapist of that era was mostly concerned with the psychiatric area (though not solely), and with occupying the patient's time beneficially through some form of occupation, thus *occupational*. About this same time Dr. Dunton was using the term "occupation therapy," further evidence for the derivation of our pres-

ent term. However as we use the term today we are concerned with more than just occupations, especially in the physical disabilities area. Training in the ADL area can not be considered to be using occupations for their therapeutic value. Here we are using activities as an end in themselves, not as was the original conception of using activities or occupations as a means to an end. When we teach a child to relax, we may use as a subterfuge a toy or some other object to gain the child's attention, but the relaxation comes through the child himself and through the good rapport of the therapist. Occupations, per se, play little or no role in this particular form of therapy. Yet this too is occupational therapy. I think it is fair to say that "occupying" by some of the types of activities used in the physical disabilities area is not implied in the term "occupational therapy," and we as therapists closely working with this modality have unconsciously read this into the term, which unfortunately the layman and many medical personnel do not. Today the practice of occupational therapy has become well established in the areas of tuberculosis, cerebral palsy, upper extremity disabilities, pediatrics and several other specialty areas, whereas when the term was first used its main use was in the psychiatric area. A quick look at some of these diagnostic areas reveals some pertinent facts. The practice of occupational therapy in the tuberculosis area has not only an objective of constructive activity in both passing time and increasing work tolerance but also has as in the case of a post-thoracoplasty, the therapeutic objective of maintaining and increasing the range of motion and muscle strengthening. One would not sense these latter objectives from the term "occupational therapy." In the cerebral palsy area the habilitation of the individual and the testing and training of the patient in the activities of daily living area are prime objectives of occupational therapy. However, one would not sense these objectives from the term "occupational therapy." In the wide area of upper extremity disabilities among the objectives of occupational therapy are coordination training, muscle strengthening, increasing the range of motion, the construction of splints, and upper extremity prosthesis training. Again one would not sense these objectives from the term "occupational therapy." And so it goes. One could now argue here that it is not necessary for the term "occupational therapy" to connote any objectives, and to this I would agree. However the term should not imply misleading objectives as does "occupational therapy." It would be far better to use a term which has no meaning to the ordinary person, than to use one that is already biased by other meanings in everyday usage. To follow this line of reasoning to its logical conclusion, one could then say it would be better to make up, or "coin", a word than use one that is already biased by previous usage. For one of our biggest jobs is educating the lay public, as well as some medical personnel, to what occupational therapy is and as we all know it is more difficult to undo a misconception, as the word *occupational* would imply, than to teach where no conception exists.

Now as I have already stated, as far as using a term from our present vocabulary I can think of none better than "occupational therapy." However, if I were to coin a word I would choose the term "physiocc" therapy to describe our present practices. Occupational therapy (or physiocc therapy) as practiced today runs the gamut of diagnostic categories with the physical restoration type of patient at one end and the hospital industries and prevocational types of patients at the other end. It is therefore logical to coin a word that is all inclusive in its nature. *Physi* takes in the physical objectives of the therapy (one end), and *occ* the pre-vocational objectives (other end). I did not feel it was necessary in coining a word to take in the psychological aspects of the therapy as this is basic to us as therapists in the dynamics of our therapy, but means little or nothing to the lay person. To some therapists the *physi* portion of "physiocc" may be objectionable because of its nearness to physiotherapy. The reasoning I use to counter this objection is to point out that (1) the doctor of physical medicine, the physiatrist, did not see any objection in using the *physi* portion even though it had been used many years previously by the physical therapist, and (2) the term "physiotherapist" is on the way out and gradually being replaced by "physical therapist," so that the confusion caused should be minimal. The fact is it would probably be well to use a *physi* stem, to more closely identify us with the physical medicine team. Also, the term "physiocc" therapy could be retained in the future if the trend established in Puerto Rico and Canada of combining physical and occupational therapy ever caught on in the United States. The physical component is present in both therapies and the name could well apply to a combined group.

The term "physiocc" therapy may or may not have merit but the important thing for us as therapists to remember is that we should recognize the drawbacks to the term "occupational" therapy and if anyone should in the future come forward with a better name we should seriously consider the possibility of adopting it, weighing both the pros and cons. We should under no circumstances ever take the stand that just because we used the name "occupational therapy" for the past thirty-eight years we can not substitute a better name. If this were the case the term "cerebral palsy" would never have supplanted "spastic", and the term "polio" would not have supplanted "infantile paralysis" (even though we still occasionally hear both of the outmoded terms). It is possible to replace a well established name with another name, and in most instances where this has been accomplished it has been for the better. Let us always keep this in mind.

Sincerely yours,
Harold Shalik, O.T.R.

Dear Editor:

In going over the July-August issue of AJOT, I was particularly interested in Dr. William Rush Dunton's editorial which quoted a term recently suggested by Dr. William Terhune, Medical Director of the Silver Hill Foundation in New Canaan, Conn. Meanwhile I have added this brochure mentioned by Dr. Dunton to our professional library here at Treasure Valley, after first reading it with the greatest of interest from cover to cover.

It has occurred to me that there is a deal of material here that might be of interest to readers of AJOT if permission were obtained to reprint some of the especially pertinent remarks. In case you have not seen this little pamphlet yourself, I shall explain that it is a compilation of the papers presented at the fifth annual meeting of the medical council of the Silver Hill Foundation. This meeting, to quote the brochure, "was devoted to occupational and avocational therapy," and presumably this was done in connection with the opening of the new avocational therapy building at Silver Hill.

Much that was said on this occasion, back in 1951, should not only interest but challenge the members of our profession. And it seems to me that the effectiveness (and affectiveness, yes?) of much that was said is heightened by the fact that at this gathering we find physicians talking to each other about occupational therapy and the extent to which it is or is not meeting the needs of patients.

Yours very sincerely,
(Signed)
Martha Eliot Buttenheim, O.T.R.
Co-Director, Treasure Valley

[Editorial note: It is a Journal policy not to print articles that have previously been printed as such material is always available from the original source.]

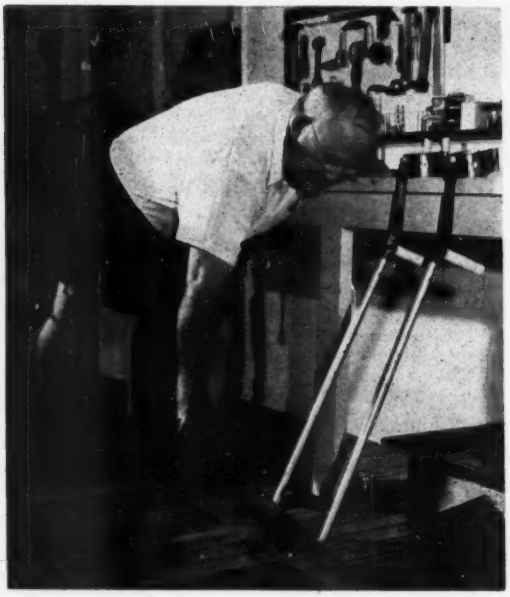
FEATURED O.T. DEPARTMENTS

REHABILITATION CENTER

Worcester, Massachusetts
Elizabeth Schoppe
Director of Information Services

How high is a bus step? This question never enters the minds of most persons as they climb in and out of a bus, but occupational therapists and others working with the crippled and handicapped know the height of a step presents a problem.

At the Rehabilitation Center of Worcester the treatment program of patients is adapted to normal activity and uniquely to the physical and financial



In his treatment, this 58-year old patient demonstrates balance activities by picking up objects from the floor unassisted. Diagnosis is hip disarticulation secondary to cancer.

limitations of the center. Instead of having a bus step, the patient is taken on a bus. Instead of having a fake curbstone, the patient is taken to a quiet street where he learns to step up and down. As his tolerance increases, he is accompanied to a busier street where his actions are timed and he learns how many steps are necessary to cross safely with the traffic light.

"We have found it far better to help a patient adjust to normal living by living normally," according to Mrs. Phyllis L. Breuninger, O.T.R., head of the occupational therapy department. "A minimum of adapted equipment is used, but we are convinced that we get along farther and faster in establishing a patient's independence under actual day to day activities than by using gadgets and reconstructed equipment."

Weaving for shoulder abduction, elbow flexion, and extension is this 40-year old woman with a diagnosis of rheumatoid arthritis. The therapist is Mrs. Phyllis L. Breuninger, O.T.R., of the Rehabilitation Center of Worcester, Mass.

It is the belief of the Bay State Society for the Crippled and Handicapped, Inc., which operates the Worcester Center, that many disabilities need not constitute handicaps and that the physically disabled should be given every opportunity to contribute to society to the fullest extent of their abilities.

Whether it be a child or adult, handicapped at birth or disabled by accident, it is the purpose of the Society to help them overcome their handicaps and to train them to their fullest potential so that they may be happy, useful citizens.

Core of the Bay State Society's state-wide program, supported by Easter Seals, is its rehabilitation centers such as the one in Worcester which provides needed services to the handicapped in 60 cities and towns comprising Worcester County.

The first facility of its kind opened to the general public in Massachusetts, the Center was organized in 1948 when a survey revealed need in the area for specialized services on an individual basis. Since then, this out-patient facility has given more than 14,000 therapy treatments, of which approximately 7,000 have been occupational therapy, to nearly 700 handicapped children and adults.

Of particular significance, Mrs. Breuninger believes is the Center's closely integrated program of therapies.

A 40-year old woman with a frozen shoulder secondary to tenosynovitis of the extensor tendons, right hand, braid weaves for shoulder flexion.

"Integration of occupational therapy with physical and speech therapy and with social service cannot be stressed too often," she said. "Without this close relationship, complete rehabilitation is impossible."

As an example, Mrs. Breuninger cited a crane operator, who lost the fingers of his left hand and was referred to the center by his physican for physical and occupational therapy.

The patient was anxious to return to his former employment. The center checked with the patient's firm on working hours; to find out how many pounds the man must pull while on the job. Did he have to climb into the crane? Was there a ladder? How long was the ladder? The center checked on how the patient went to and from work; by public transportation, or did he drive?

With this information, a program was adapted, under the medical director's supervision, which simulated the requirements of the patient's job.

When the patient developed the strength to perform and the working tolerance necessary to put in an eight-hour day, he was able to leave the center and return to his job without complications or problems.

Among the persons treated in the occupational therapy department are those suffering from industrial accidents; from nerve injuries, amputations, fractures, burns and lacerations. An equally large number receiving treatment are persons suffering from multiple sclerosis, arthritis, polio, Erbs palsy, cerebral vascular accidents, congenital defects and children over 12 years of age with cerebral palsy.

The Center sends monthly reports on a patient's progress to his referring physician and in the case of an industrial accident, to the insurance company. A medical social worker maintains a close follow-up before and after the patient is discharged, and in the case of a person who cannot return to former employment, directs him toward other available community resources.

In addition to the occupational therapy given within the Center, the department has organized a program for the homebound. Working with Mrs. Breuninger in this project, is a craft volunteer, a woman highly skilled in her field, who instructs homebound patients in diversional therapy. Mrs. Breuninger acquaints the volunteer with the patient's disability and as much information as is available from the referring physician. An individual program, best suited to the patient's needs, is then developed.

An occupational therapist, if she is to serve the needs of the patient, Mrs. Breuninger believes, must keep informed of the developments in other therapies as well as her own.

"Complete satisfaction with the job you are doing denotes lack of progress," she says. "Dissatisfaction promotes new goals to be met in service to the community."

HIGHER EDUCATION

(*Continued from page* 254)

cerebral palsy should experience in the guidance process:

1. Inclusion in planning so that his wishes may be expressed and respected.
2. Re-direction toward realistic goals.
3. Satisfactory adjustment to those goals.
4. Compensatory activities to aid in self-realization.
5. Encouragement to meet competition in physical, social, recreational and emotional areas.
6. Instruction in the implications of work habits, quality and perserverance.
7. Evaluation and adjustment procedures that begin early in life.
8. Education and guidance of his parents.
9. Cooperation from and coordination of all disciplines. (He is not solely a medical problem, nor an educational one, nor a vocational one, nor a psychological one.)

The adolescent with cerebral palsy should not have opportunity withheld from him. During his entire life his experiences have been restricted. Let us not continue to superimpose our prohibitions upon nature's.

DELEGATES DIVISION

TEXAS

Delegate-Reporter, Cornelia Anne Watson, O.T.R.

This past year has been a very busy and profitable one for the members of the Texas Occupational Therapy Association. The annual conference of TOTA was held in San Antonio on April 25th and 26th, with the Army therapists serving as hostesses. Approximately 100 members were able to attend this meeting. Speakers covered aspects of vocational rehabilitation, radiological warfare, and aspects of the treatment of poliomyelitis and psychiatry. Aside from this educational program, the Texans spent many hours in smaller meetings, planning for the Houston conference in November.

Consideration has been made of the formation of districts within the present organization of the Association to allow for monthly meetings, but further action on this matter will not be taken until next year. In effect these districts have been functioning already in the form of small local committees to work on the many facets of the Houston conference.

The results of the work in the recruitment committee have been satisfactorily felt by an increased interest in OT.

The main theme of thought and work throughout this past year has been on the success of the Houston conference. As with the AOTA, there have been many changes in both personnel and names the past year. Some of these have affected the functioning of TOTA. Our president, Mary Britton, has left the state, and as yet there has not been an election to fill the now vacant vice-presidency.

OFFICERS

President ..... Miss Dorothy Sniffin, O.T.R.
Vice-President ..... to be filled
Secretary ..... Miss Gladys Irene Greer, O.T.R.
Treasurer ..... Mrs. Dorothy Hines, O.T.R.
Delegate ..... Miss Cornelia Anne Watson, O.T.R.
Alternate ..... Miss Martha Parr, O.T.R.

* * *

DISTRICT OF COLUMBIA

Delegate-Reporter, Althea Warner, O.T.R.

The goals of our association this past year have been two-fold, namely: (1) to have our meetings more varied in program and locale, (2) to prepare for the 1954 conference. We feel that we have made good progress toward these goals.

Eight meetings were held during the year. The meeting places were varied and included the Forest Glen Section of Walter Reed Army Medical Center, Kabat-Kaiser Institute, District of Columbia General Hospital, Division of Pulmonary Diseases, Mt. Alto Veterans Administration Hospital, St. Elizabeths Hospital and the Corcoran Gallery of Art.

The programs included speeches, movies and demonstrations on subjects varying from aphasia and the fitting and training of upper extremity amputees to contemporary and old masters of art and leatherwork, lapidary and metal etching. We had two dinner meetings and refreshments were served at most of our get-togethers.

Fund-raising for the conference has been done painlessly and in fact with considerable fun and amusement in the form of a Chinese auction at almost every meeting. In addition we have sold calendars and contributed to the fund when given transportation to the meetings.

There have been several meetings with the Virginia and Maryland representatives and progress has been made in the organizational planning for the 1954 conference. Miss Mary Beach of our association was appointed local general chairman and Mrs. Arvilla Merrill, co-chairman. The conference committee have been divided among the three associations and the chairmen have been appointed.

We are all looking forward to the 1954 conference and you will be hearing more details of our plans in the future.

OFFICERS

President ..... Capt. Norine Ginder, WMSC, O.T.R
Vice-President ..... Milton Fisher, O.T.R.
Secretary ..... Barbara Beard, O.T.R.
Treasurer ..... Margaret Downs, O.T.R.
Delegate ..... Althea Warner, O.T.R.
Alternate Delegate ..... Rena Graham, O.T.R.

* * *

WISCONSIN

Delegate-Reporter, Norma Smith, O.T.R.

The Wisconsin Occupational Therapy Association thought it would have a quiet year after the 1952 convention but we found ourselves with an interesting and profitable program lasting throughout the entire year.

Our first meeting began in October with a talk on glass and china, the second was held in Madison at the new Veterans Hospital followed by a tour and talk on ceramics at Century House. Next we visited the Goodwill Industries and watched a movie on their various activities. At our fourth meeting we heard a talk on rehabilitation by Dr. Hayes who is in charge of the physical medicine department at Milwaukee's St. Luke's Hospital. A demonstration of the wet technique in watercolor was enjoyed by both physical and occupational therapists at the Layton School of Art. Our annual banquet and business meeting was in May.

Other activities include the booklet, *Quiet Without Riot,* which was published by the Wisconsin Heart Association and written by occupational therapists for the child with rheumatic fever that is at home in bed. Since the Wisconsin Association is rather old, an effort is being made to collect our historical material and organize it.

This year Wisconsin has added Fellows to the Association. We hope they will benefit from us and we are looking forward to their professional help. The Fellows include Dr. Andrew Banyai, who graduated from the University of Budapest Medical School in 1915. He became clinical director of Muirdale Sanatorium in 1928 and at present is an associate clinical professor of medicine at Marquette Medical School and a diplomate of the American Board of Internal Medicine. Dr. Banyai is recognized as the originator of the artificial pneumoperitoneum treatment of pulmonary tuberculosis. He has written extensively and is a member of the editorial advisory committee of the American Journal of Occupational Therapy.

Dr. Raymond Waisman graduated from the University of Wisconsin Medical School in 1940, and had a fellowship at Children's Rehabilitation Institute at Cockeysville, Md. He has been medical director of the Cerebral Palsy Clinic in Milwaukee since its inception. He has a private practice in orthopedic surgery and is on many of Milwaukee's hospital staffs. He has always been a strong supporter of occupational therapy and is one of our boosters.

Dr. Raymond Piaskoski, or Dr. Pi as he is usually known, graduated from Marquette Medical School. He is certified by the American Board of Physical Medicine and Rehabilitation and served as chief of physical medicine at

(*Continued on page* 270)

Schools Offering Courses in Occupational Therapy

Boston School of Occupational Therapy, Affiliated with Tufts College, 7 Harcourt St., Boston, Mass. *Mrs. John A. Greene, President*

Colorado Agricultural and Mechanical College, Fort Collins, Col. *Asst. Prof. Marjorie Ball, OTR, Director of O.T.*

Columbia University, College of Physicians and Surgeons, 630 W. 168th St., New York 32, N.Y *Ass't Prof. Miss Marie Louise Franciscus, OTR, Director of Training Courses in O.T.*

Illinois, University of, College of Medicine, 1853 West Polk St., Chicago 12, Ill. *Assoc. Prof. Beatrice D. Wade, OTR, Director of O.T.*

Iowa State, University of, College of Liberal Arts and College of Medicine, Iowa City, Iowa. *Ass't. Prof. Elizabeth Huntsberry, OTR, O. T. Supervisor*

Kalamazoo School of Occupational Therapy, Western Michigan College of Education, Kalamazoo 45, Michigan. *Assoc. Prof. Marion Spear, O.T.R., Director of O.T.*

Kansas, University of, School of Occupational Therapy, Lawrence, Kansas. *Asst. Prof. Nancie B. Greenman, OTR, Director of O.T.*

Michigan State Normal College, Ypsilanti, Michigan, *Asst. Prof. Frances Herrick, OTR, Director of O.T.*

Mills College, Oakland 13, Calif. *Mrs. Anne N. Turchi, OTR, Director of O.T.*

Milwaukee-Downer College, 2512 E. Hartford Ave., Milwaukee 11, Wis. *Prof. Henrietta McNary, OTR, Director of O.T.*

Minnesota, University of, School of Medicine, Minneapolis, Minn. *Miss Borghild Hansen, OTR, Director of O.T.*

Mount Mary College, Milwaukee 13, Wis. *Sister Mary Arthur, OTR, Director of O.T.*

New Hampshire, University of, College of Liberal Arts, Durham, N.H. *Miss Esther Drew, OTR, Supervisor of O.T.*

New York University, School of Education, Washington Square New York 3, N.Y. *Assoc. Prof. Frieda Behlen, OTR, Director of O.T.*

Ohio State University, College of Education, Columbus 10, Ohio. *Miss Barbara Locher, OTR, Chairman, O.T. Dept.*

Pennsylvania, University of, School of Auxiliary Medical Services, 419 South 19th Street, Philadelphia 46, Pa. *Prof. Helen S. Willard, OTR, Director*

Puget Sound, College of, N. 15th and Warner St., Tacoma 6, Wash. *Ass't. Prof. Shirley Bowing, OTR, Director of O.T. and Rehabilitation*

Saint Catherine, College of, St. Paul 1, Minn. *Sister Jeanne Marie, OTR, Director of O.T.*

San Jose State College, San Jose 14, Calif. *Asst. Prof. Mary Booth, OTR, Director of O.T.*

Southern California, University of, College of Letters, Arts, and Sciences, Box 274, Los Angeles 7, Calif. *Assoc. Prof. Angeline Howard, OTR, Director of O.T.*

Texas State College for Women, Dept. of Art, Denton, Texas. *Assoc. Prof. Fanny Vanderkooi, M.A., Supervisor of O.T.*

Texas, University of, Medical Branch, Galveston, Texas. *Miss Elyda A. Seely, OTR, Director of O.T.*

Washington University, School of Medicine, 4567 Scott Ave., St. Louis 10, Mo. *Ass't Prof. Erna R. Simek, OTR, Director, Dept. O.T.*

Wayne University, College of Liberal Arts and College of Education, Detroit 1, Michigan. *Asst. Prof. Barbara Jewett, OTR, Director of O.T.*

William and Mary, College of, Richmond Professional Institute, 901 W. Franklin St., Richmond 20, Va. *Miss H. Elizabeth Messick, O.T.R., Director of O.T.*

Wisconsin, University of, School of Medicine, 1300 University Ave., Madison 6, Wis. *Asst. Prof. Caroline G. Thompson, OTR, Director of O.T.*

Have You Tried?

A new treadle wheel is now being produced by Craftools, Inc., that is adjustable in height and has a foot treadle that can be used for left or right action, two features that should prove invaluable to occupational therapists.

* * * *

Moore Engineering Company of Los Angeles, makers of the unique KNIFORK for one-handed eating, has just announced development of a new SPECIAL KNIFORK for use of handicapped people who do not have even normal use of one hand.

After consultation with occupational therapists, a KNIFORK HANDLE was designed that can be held in the desired position with a minimum of effort. It is made of heat-resistant Ivory phenolic plastic which can be boiled. The KNIFORK is of highly polished stainless steel.

The SPECIAL KNIFORK adds a great deal of eating enjoyment to the handicapped.

DELEGATES

(*Continued from page* 268)

Nichols General Hospital in Louisville, Ky. At present he is director of physical medicine at Wood Veterans Hospital, and is professor and director of the department of physical medicine at Marquette University.

Dr. Benjamin Glover graduated from Northwestern University Medical School, served his internship in the Navy at Bremerton, Washington, and his psychiatric residency at Bethesda, Maryland, and at St. Elizabeth's Hospital, Washington, D.C. Subsequently he served as 13th Naval district psychiatrist at Jacksonville, Florida. Since 1947 he has been assistant professor of neuro-psychiatry at the University of Wisconsin Medical School.

OFFICERS

President ..... Mrs. Marion Hartman, O.T.R.
Vice-President ..... Dorothy Lauson, O.T.R.
Secretary ..... Elizabeth Jermain, O.T.R.
Treasurer ..... Madeline Gumina, O.T.R.
Delegate ..... Norma Smith, O.T.R.
Alternate Delegate .....Mrs. Janice Gundlach, O.T.R.

TEACHING OF WRITING

(*Continued from page* 249)

sary for writing she will not become easily discouraged or frustrated in her efforts and will find success.

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GROUP PROJECTS

(*Continued from page* 253)

or painting jobs. Whenever possible two or three were asked to work on one part of the project in an effort to bring about cooperation, group spirit and socialization.

With the above basis for reality established, it was not difficult to arouse interest in further projects. These included a large, complicated, folding marionette stage and platform (8'x12') complete with backdrop, scenery and footlights. This project seemed to be our most successful venture.

The accomplished aim of this experiment was a healthier acceptance by many of these patients of group living, necessitated by hospitalization.

REHABILITATION CENTER

(*Continued from page* 246)

16. Frederick A. Whitehouse, "A Study of Vocational Rehabilitation in a Rehabilitation Center," unpublished doctoral dissertation, New York University, 1952, pp. 486-7.
17. Kenneth W. Hamilton, *Counseling the Handicapped,* p. 67.
18. Henry H. Kessler, *Rehabilitation of the Physically Handicapped,* p. 236.

Book Reviews and Abstracts

REHABILITATION
of the
Physically Handicapped
Henry H. Kessler
Published by
Columbia University Press

New York City, 1953 275 pages, $4.00

This is a revised edition which includes the same wide coverage as the previous edition. Emphasis is on the treatment of the individual as a whole and the problems the physically handicapped meet in an attempt to "adjust their limited physical equipment to the demands of living in a social environment."

Detailed treatment of the mentally and emotionally disabled, the orthopedic patient, the blind and deaf and the invalid are included as well as the principles of rehabilitation and rehabilitation as it is practiced. Special note is made of legislation and administration.

DOING SOMETHING FOR THE DISABLED
Mary E. Switzer and Howard A. Rusk, M.D.
Public Affairs Committee, Inc., 22 E. 38th St.,
N. Y. C., 25c.

The value of rehabilitation in the saving of money and the returning of people to productive, satisfying lives is the context of the pamphlet, *Doing Something for the Disabled.*

The authors point out, for example, that it costs less than three-fourths as much to retrain sick and crippled men and women for useful jobs than to maintain them in relief for a single year.

The success of work with handicapped workers rests on two principles, the authors declare. "First, they must be properly prepared—physically, vocationally and otherwise—for the job they will do"; and "the second key to success is selective placement."

"Wherever organized programs for placing the disabled have been launched, the experience has confirmed the belief that handicapped workers can be hired with just as much confidence and success as any other group of workers with no impairment," they add.

"The greatest single obstacle to the more rapid development of all types of rehabilitation services," they continue, "is the shortage of trained personnel."

"Although the number of physicians receiving specialized training in physical medicine and rehabilitation has increased by ten times since before World War II, the supply still falls far short of meeting the needs. The need for physical therapists, occupational therapists, speech and hearing therapists, vocational counselors, social workers, and other specialists is even greater."

"Because this question of disability, and the burden

that it imposes in terms of dollars and human misery, is common to every community, the logical starting place," the authors contend, "must be the cities, towns and villages throughout the country . . . State and national planning is of little value unless it bears fruit in the form of action in the communities across the land."

"When our friends, neighbors and colleagues acquire insight into the problem of disability, when they realize that a rehabilitation program will reduce the drain on municipal funds, community action will follow."

"The handicapped people of our country," the authors conclude, "ask no more than the opportunity to compete on an equal basis for the privilege of living in a democratic society."

THE TROUBLED MIND

Beulah Chamberlain Bosselman, M.D.
Published by
The Ronald Press, New York
206 pages 1953 $3.50

A simple descriptive analysis of personality disorders and how they arise. The book is written for the layman and discusses the changes in character at the various age levels, the neuroses, the psychoses and the agencies of health prepared to deal with emotional disorders. However no mention was made of occupational therapy and its part in dealing with personality problems.

PSYCHOLOGICAL ASPECTS OF PHYSICAL DISABILITY

Office of Vocational Rehabilitation, 195 Pages, 45c

A symposium which presents a general study of the rehabilitation team in relation to the disabled individual with special emphasis on the "total" treatment of the patient. A brief summary of the psychiatric aspects of physical disability is followed by some psychological factors presented by the patient and suggestions for helping him re-evaluate himself.

This brief survey of the general problems of the disabled preceded specific studies of poliomyelitis, paraplegia, cerebral palsy, multiple sclerosis, amputations, tuberculosis, facial disfigurements, the deaf, hard of hearing, partially seeing and the blind.

Each chapter was written by a well known author in the various specialties. Emphasis is on the individual and the best way he may accomplish his rehabilitation.

HEMIPLEGIA AND REHABILITATION

Howard A. Rusk, M.D., in collaboration with
George G. Deaver, M.D., Donald A. Covalt, M.D.
and Mrs. Martha Turnblom

Reviewed by: Margaret L. Blodgett, O.T.R.

This monograph is published by Sharp and Dohme from material in their publication *Seminar* of January and February, 1952. Copies may be requested from the Professional Service Department, Sharp and Dohme, West Point, Penna.

Clearly written, giving a wealth of background medical material, this publication summarizes the whole problem of the hemiplegic and is of inestimable value to the practising occupational therapist. Starting with the vascular diseases of the central nervous system, it sets forth the clinical aspects of the acute phase, goes on to its prognosis and treatment and then to the treatment of residual defects. In this latter section the problem and management of aphasia is discussed, with an excellent definition and explanation of the classifications of aphasia, the recognition and treatment of the various symptoms and the final emphasis on practical methods of rehabilitation. Charts and pictures enhance the interest of the monograph and an outstanding bibliography completes the issue.

For those whose experience with this type of patient is just beginning, or for use in teaching student therapists, this monograph is of inestimable help. It summarizes the current literature and teaching on the subject, gives the necessary medical background knowledge and goes on to the best accepted teaching and emphasis on the rehabilitation of the whole patient.

THE WELL-ADJUSTED PERSONALITY

Phillip Polatin, M.D., and Ellen C. Philtine

J. B. Lippincott Co., 1952, 22 Pages, $3.95.

A very basic and practical approach to the every day problem of living. Written for the layman, it is a guide to help those who wish to help themselves. Emotional problems of every variety are discussed and clarified. Emphasis is on the prevention of faulty emotional concepts and a recognition of emotional resources and their variations within an individual.

MAKING LIFE LONGER AND BETTER: MEDICAL POTENTIALITIES

Edward L. Bortz, M.D.
Geriatrics
Vol. 8, No. 9, September, 1953

A treatise on the goals to be achieved rather than on past developments in maturity potentialities. "Social progress largely depends on the utilization of mature minds when individuals have lived long enough to acquire knowledge, experience, and understanding." Goals for the utilization of our great facilities of social medicine are suggested for the betterment of the individual physically and mentally.

THE ROLE OF THE PHYSICAL THERAPIST IN THE MANAGEMENT OF PATIENTS WITH MULTIPLE SCLEROSIS AND OTHER DEMYELINATING DISEASES

Robert L. Leopold, M.D.
The Physical Therapy Review
Vol. 33, No. 9, September, 1953

A clear, well presented discussion of the clinical syndrome of multiple sclerosis. Dr. Leopold presents the essential pathological changes and the treatment necessary for the rehabilitation of the patient. Although concerned with the physical symptoms, the value of the article is enhanced by the concern Dr. Leopold shows in the psychological disturbances which always present a problem in effectively executing the treatment program.

LIVING WITH A DISABILITY

Howard A. Rusk, M.D.
and
Eugene J. Taylor
Published by
The Blakiston Company, Inc.
202 pages 1953 $3.50

A beautifully illustrated, carefully written book of selected equipment and methods for doing everyday activities although handicapped. Besides suggested methods for dressing, feeding and working, additional ideas are included for living within the homes and for hobbies for both men and women.

REPRINTS

Reprints are convenient for teaching files in hospitals. If you would like a few copies of articles appearing in this issue, your order will be honored if enough requests are received to total the minimum order of 50 for an article. Orders should be placed before the 25th of the month of publication.

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Immediate opening for chief occupational therapist. Well equipped out-patient center established 1951 offering nursery-school, occupational, speech and physical therapy to pre-school children. Starting salary up to $4500. Five day week, four weeks summer vacation, ten day Christmas holiday. Write Miss Virginia Pettit, Director, Cerebral Palsy Center, 3601 Victory Parkway, Cincinnati, Ohio.

Hospital director of rehabilitation therapies ($4265-$5115), head occupational therapist ($3761-$4511), and staff occupational therapists ($3320-$3980) wanted for psychiatric hospitals. State Civil Service tenure of position, 3 weeks paid vacation, sick leave, liberal retirement, and other benefits. Apply at once Department of Mental Hygiene, 2218 N. Charles Street, Baltimore 18, Maryland.

Wanted: an experienced occupational therapist to assume duties of chief occupational therapist. Good personnel policies. New rehabilitation center to open January 1, 1954. Write Gerrit H. Wiegerink, Executive Director, Grand Rapids Rehabilitation League, 941-943 Wealthy Street, S.E., Grand Rapids, Michigan.

Occupational therapist, $3360 per annum, Civil Service benefits, yearly salary raises. Contact Personnel Director, New Jersey Neuro-Psychiatric Institute, Skillman, N. J.

Wanted: Occupational therapist for work in cerebral palsy treatment center. Good salary. Good working conditions. Scholarship available for additional training in cerebral palsy. Program directed by diplomate of the American Board of Physical Medicine. Write Herman L. Rudolph, M.D., 400 North Fifth Street, Reading, Pennsylvania.

Wanted: Director of occupational therapy for well established curative workshop in college town. Experience necessary, 5 day work week, salary open. For further details write Mrs. Rachel Wood, 183 Milford, East Lansing, Michigan.

Fairfield State Hospital, Newtown, Conn. Occupational therapists and senior occupational therapists. $3,120-$4,620; 40-hour week; well-equipped working units; good living facilities; clinical training program.

Immediate opening: Registered occupational therapist for 350 bed tuberculosis hospital. Paid vacation, sick leave, retirement plan and uniform laundry. Staff occupational therapist positions available, also. Apply: State Tuberculosis Board, P.O. Box 286, Tallahassee, Florida.

Topeka State Hospital invites applications from men and women occupational therapists. Progressive program in all areas of psychiatry with national recognition. Excellent opportunity with vacation, sick and retirement benefits. Salary $3360 to $4980. Apply Personnel Officer, Topeka State Hospital, Topeka, Kansas.

California Department of Public Health has positions in various cities throughout the state. $341 to $415. Requires registration with national registry of qualified occupational therapists and one year or more experience. New graduates may start at $310. Liberal vacation and retirement benefits. Write Dept. OT, State Personnel Board, 1015 L Street, Sacramento 14, Calif.

Wanted: Occupational therapist for cerebral palsy adult night program in New Orleans. Contact Mrs. Albert S. Williams, Executive Director, UCPA of New Orleans, 6122 Painters Street, New Orleans, Louisiana.

Occupational therapists' positions available with adults or children in psychiatric teaching hospital, 10 miles from Boston, progressive department, student affiliations, civil service benefits, maintenance optional. Write: Head O. T., Metropolitan State Hospital, Waltham 54, Mass.

Occupational therapist for 1150 bed psychiatric hospital. Salary $235 plus full maintenance. Five and one half day week. Liberal vacation, sick leave and holidays. Retirement benefits. Write C. G. Stillinger, M.D., Supt., New Mexico State Hospital, Las Vegas, New Mexico.

Position open for registered occupational therapist in the private practice neuropsychiatric department of the Hertzler Clinic and Halstead Hospital, Halstead, Kansas. 40 bed active treatment and training center. Write Mr. Walton Goode, Business Manager, The Hertzler Clinic, Halstead, Kansas.

O.T.R. to assist director of occupational therapy with established program in a state tuberculosis hospital. Excellent experience afforded. 40 hr. week; paid vacations and sick leave. Liberal retirement plan. Salary $3571-$4372. Write to: Supervisor, Occupational Therapy, N. Y. State Department of Health, Division of Tuberculosis Control, 28 Howard Street, Albany 7, N. Y.

Occupational therapist wanted to work with rheumatic fever children. Expanding department with excellent facilities. Graded activity and psychological program. Salary open. Apply: Director of O.T., La Rabida Sanitarium, E. 65th & South Shore Drive, Chicago, Ill.

Two positions open at Pontiac State Hospital, Pontiac, Michigan. Progressive, teaching, institution; clinical training center. Salary $3,587 to $4,363, forty hour week. Michigan Civil Service benefits. Apply to Personnel Officer.

Occupational therapist to set up and run O. T. program in 400 bed TB hospital, salary $3360-3960 plus maintenance if desired, N.Y.C. metropolitan area. Contact T. F. Finn, Superintendent, B. S. Pollak Hospital, Jersey City, New Jersey.

Wanted immediately: occupational therapist for cerebral palsy training center in Fall River, Mass. Therapist will have complete charge of occupational therapy department. Salary is open depending on qualifications and experience. Five day week, and month of August vacation with pay, also paid holidays. Contact Dr. W. H. Kenney, 218 Calvin St., Fall River, Mass.

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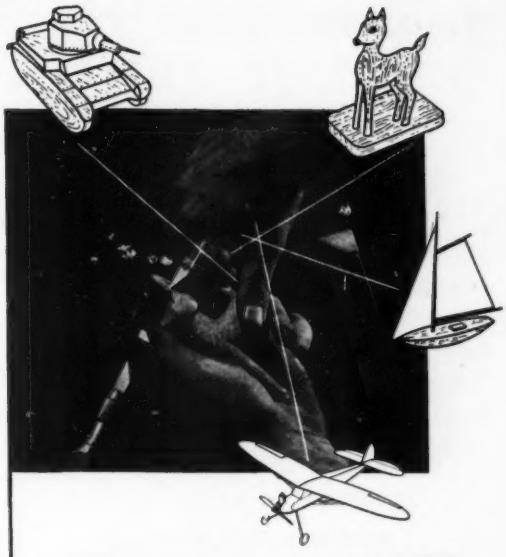

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